COPY

Lauderdale Community Hospital

CN1601-004

LAUDERDALE COMMUNITY HOSPITAL
326 Asbury Avenue
Ripley, Tennessee 38063
Phone: 731-221-2200

January 13, 2016

VIA FEDERAL EXPRESS

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37243

RE: Certificate of Need Application
Replacement Hospital
Lauderdale Community Hospital, Ripley, Tennessee

Dear Sir or Madam:

Enclosed for filing are the original and two copies of the Certificate of Need prepared for a Replacement Hospital at Lauderdale Community Hospital.

Tammie Hardy at the hospital is the contact person for the project. If you require additional information, you can also contact the undersigned at 816-474-7800.

Thank you for the opportunity to work with the agency to replace this hospital. We look forward to working with you.

Sincerely,

Trent Skaggs

CERTIFICATE OF NEED APPLICATION

FOR A REPLACEMENT HOSPITAL AT

LAUDERDALE COMMUNITY HOSPITAL

JANUARY 2016

CONTACT:
TAMMIE HARDY
CHIEF EXECUTIVE OFFICER
LAUDERDALE COMMUNITY HOSPITAL
326 ASBURY AVE
RIPLEY, TN 38063
731-221-2200

1. ***Name of Facility, Agency, or Institution***

CAH Acquisition Company 11, LLC
Name

326 Asbury Avenue
Street or Route

Lauderdale
County

Ripley
City

TN
State

38063
Zip Code

2. ***Contact Person Available for Responses to Questions***

Tammie Hardy
Name

Chief Executive Officer
Title

Lauderdale Community Hospital
Company Name

tammie.hardy@lauderdalehos
Email address

326 Asbury Avenue
Street or Route

Ripley
City

TN
State

38063
Zip Code

Employee
Association with Owner

731-220-2400
Phone Number

731-220-2499
Fax Number

3. ***Owner of the Facility, Agency or Institution***

CAH Acquisition Company 11, LLC
Name

731-220-2200
Phone Number

326 Asbury Avenue
Street or Route

Lauderdale
County

Ripley
City

TN
State

38063
Zip Code

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship	F.	Government (State of TN or Political Subdivision)
B.	Partnership	G.	
C.	Limited Partnership	H.	Joint Venture ✓
D.	Corporation (For Profit)	I.	Limited Liability Company
E.	Corporation (Not-for-Profit)		Other (Specify)_____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

Rural Community Hospitals of America, LLC
Name

1100 Main Street, Suite 2350
Street or Route

Jackson
County

Kansas City
City

MO
State

64105
Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	✓	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify)	
C.	Lease of ____ Years				

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) CAH	✓	I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		K.	Recuperation Center	
D.	Home Health Agency		L.	Rehabilitation Facility	
E.	Hospice		M.	Residential Hospice	
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility	
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify)	
			Q.	Other (Specify)	

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A.	New Institution		G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B.	Replacement/Existing Facility	✓			
C.	Modification/Existing Facility				
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)		H.	Change of Location	
			I.	Other (Specify)	
E.	Discontinuance of OB Services				
F.	Acquisition of Equipment				

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical	25	25	25	0	25
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	25	25	25	0	25

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** 441314

Certification Type Critical Access Hospital

11. **Medicaid Provider Number** Z017525

Certification Type Critical Access Hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** N/A

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants?** Yes **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

See Attachment 5

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

General Information and Ownership Structure

CAH Acquisition Company 11, LLC is a Delaware Limited Liability Company. CAH 11 is authorized to conduct business in Tennessee, and is the owner of all the assets and properties of a 25-bed acute care hospital located at 326 Asbury Avenue, Ripley, Tennessee 38063. The hospital is commonly known as Lauderdale Community Hospital. Hereafter, CAH Acquisition Company 11, LLC will be referred to as "CAH11" and/or the "Applicant" and Lauderdale Community Hospital will be referred to as "LCH".

HMC/CAH Consolidated, Inc. (HMC) is the parent company of CAH11. HMC is a Delaware corporation with it principal place of business in Kansas City, Missouri. HMC is in the business of acquiring acute care hospitals located in rural communities and certified by the Centers for Medicare and Medicaid Services ("CMS") as Critical Access Hospitals. HMC conducts its business through a consolidated group of ten hospital subsidiaries.

The HMC business plan is to replace the existing facilities of all its hospitals with new facilities. In addition to LCH, HMC currently has four hospitals in Oklahoma (one of which is a new hospital facility); three hospitals in Kansas (one of which has a new hospital facility under construction); one in Missouri (which is a new hospital facility); and one in North Carolina.

LCH (and the other non-HMC hospitals) is managed by Rural Community Hospitals of America, LLC (RCHA). RCHA is a West Virginia limited liability company with its principal place of business in Kansas City, Missouri. RCHA provides LCH (and each of the other HMC hospitals) with day-to-day management and business services. RCHA has approximately 86 full-time employees, which include hospital administrators, nurses, quality improvement specialists, accountants, lawyers, financial analysts, revenue cycle and reimbursement (cost reporting) specialists, patient services coordinators, managed care contract analysts, information technology (IT) specialists, and a variety of other senior and mid-level managers.

LCH is licensed as an acute care hospital in Tennessee and is certified by the Centers for Medicare and Medicaid Services ("CMS") as a Critical Access Hospital. LCH has an inpatient census that averages around 8.5 patients per day. In FY 2015 (during the months October-September) LCH had 2,967 patient days (inpatient, swing bed and

observation) and over 10,000 emergency room (ER) visits. Baptist Memorial Hospital (BMH) in Covington, Tennessee is the closest hospital to LCH and is located approximately 20 miles away. BMH has 92 licensed beds and approximately 4,000 annual patient days.

Project Cost, Funding, and Financial Feasibility

CAH11is the owner of fee title to the real property and improvements located at 326 Ashbury Avenue, Ripley, Tennessee 38063. This tract of land is 34.95 acres, more or less. Applicant has divided this tract of land into two separate parcels consisting of 10.97 acres (Parcel 1) and 23.98 acres (Parcel 2). Parcel 1 is the tract of land on which the existing hospital facility is located. Parcel 2 is the tract of land on which the new hospital facility is proposed to be constructed.

Applicant proposes to enter into build-to-suit lease transaction for construction of the new hospital facility on Parcel 2. CAH11 (or its affiliate) will be the lessee, and Community Hospitality Healthcare Services (CHHS) will be the lessor.

The total project cost for the new hospital facility will be approximately $23 million, of which $3 million (or approximately 23%) will be New Market Tax Credits (NMTC). This investment will be provided through CHHS in the form of a subordinated interest-only promissory note with a term of no less than 7 years at an interest rate in the 2.5% to 3.0% range. The remaining $20 million will be provided by CBC Real Estate Group, LLC, the project developer, in cooperation with a real estate investment trust (REIT). Applicant has engaged CFG Capital Markets, LLC, as its financial advisor, to originate and structure this aspect of the lease transaction.

At closing of the lease transaction, the lessee will convey fee title to Parcel 2 to the lessor. The lessee will leaseback Parcel 2 (together with the 25-bed new hospital facility that is to be constructed thereon) from the lessor. The hospital facility will have approximately 46,851 square feet.

In material part the lease agreement executed by CAH11 (as Lessee) and CHHS (as Lessor) will contain the following terms and conditions:

1) Lessee will accept the leasehold property in its "AS IS" condition, and will work with the project developer (appointed by the lessor) to ensure its satisfaction with the plans, specifications, scope of work and schedule for the to-be-constructed hospital facility to ensure adequacy and acceptability for its intended use.

2) The term of the lease is twenty (20) years. The lessee shall have two, 5-year renewal options. So long as it is not in default on the lease, the lessee will have the option (at agreed intervals) to repurchase the leasehold property at a pre-established pricing methodology. The purchase option is non-transferable.

3) The lease will be absolute net in nature whereby CAH11 will be responsible throughout the term for the payment of all amounts, liabilities, obligations and impositions related to the ownership, use, possession and operation of the leasehold property. This responsibility of the lessee will be in addition to the payment of the annual rent described below.

4) The annual rent for the first 12-month period following the closing shall be an amount equal to 10.5% of the transaction less an adjustment for New Market Tax Credits (NMTC). The NMTC adjustment is expected to equal to no less than $300,000 or 10% of the value received from the New Market Tax Credits currently contemplated. Commencing on the date that is one year after lease commencement and each year thereafter, the annual rent shall be increased by one and a half percent (1.5%). The annual rent for the first year of the first renewal option shall be the greater of market rent or 101.5% of the prior year's rent. The annual rent shall be subject to annual increases of 1.5% thereafter.

5) The lessee will obtain and maintain throughout the lease term all approvals needed to use and operate the hospital facility as a Critical Access Hospital. The lessee will continuously operate the hospital facility only as a provider of healthcare services and shall maintain its certifications for reimbursement and licensure and all necessary accreditations.

Need

The new hospital will replace the existing, outdated facility that does not provide the efficiencies needed to compete in today's challenging environment. The current facility was put into service in 1983. As a result of the facility's age, operational deficiencies, accessibility issues for patients, and infrastructure challenges, significant facility upgrades or additions are not financially feasible. The intent of the proposed project will be to continue to offer the same services currently provided, which include acute, emergency, swing bed and outpatient services, but do it in a more operationally efficient manner. The intent is to improve the patient experience and create a facility that is financially sustainable and meets the future need of the region, the medical staff, and the health system.

Proposed Services, Equipment and Staffing

The proposal is to move all existing services and equipment to the replacement facility. There is no current plan to change the number or disposition of LCH's 25 beds, nor are there any planned changes in the services to be provided. No major equipment purchases are currently being contemplated. The facility employs 107 highly skilled workers and will continue to employ these employees with the replacement facility.

Service Area

LCH's primary service area consists of zip-code 38063 (Ripley, TN) which accounts for 78 percent of the hospitals total volume. The total population within the zip-code in 2018 is projected to be 17,015. The 65 plus population in 2018 is projected to be 2,744, which is 16.3% of the population.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

As noted above, the LCH existing hospital facility is a 25-bed Critical Access Hospital located at 326 Asbury Avenue, Ripley, Tennessee. The hospital is over 30 years old and outdated from layout and design to the mechanical systems. The proposed project is to construct a state-of-the-art replacement facility to replace the old one. As noted above, the new hospital facility (Parcel 2) will be located adjacent to the existing hospital facility (Parcel 1) on real property that is already owned by CAH 11. No new services or major equipment will be acquired as part of the proposed project.

The replacement facility will be located on 23.98 acres (Parcel 2) at an expected construction cost (including site preparation work) of $19,999,460.

The total cost per square foot for the replacement facility is projected to be $299 which is slightly higher than the data used by HSDA for the years 2012-14. However, considering the data is nearly two years old the construction cost per square foot is within reason and has been priced by JEDunn Construction Company.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

LCH is proposing to construct a replacement facility and is not adding or subtracting, converting or redistributing any beds. Nor will any beds be changing

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
A & G	Hospital	6893	N/A	New Facility	N/A	3044	3044			
Housekeeping	Hospital	1428	N/A	New Facility	N/A	122	122			
Dietary	Hospital	3356	N/A	New Facility	N/A	1676	1676			
Cafeteria	Hospital	1885	N/A	New Facility	N/A	1057	1057			
Central Svcs/Supply	Hospital	2538	N/A	New Facility	N/A	2396	2396			
Medical Records	Hospital	1791	N/A	New Facility	N/A	753	753			
Emp Benefits Department	Hospital	157	N/A	New Facility	N/A	104	104			
Nurse Adm	Hospital	799	N/A	New Facility	N/A	230	230			
Pharmacy	Hospital	1165	N/A	New Facility	N/A	587	587			
Adults & Peds	Hospital	21142	N/A	New Facility	N/A	9784	9784			
Operating Room	Hospital	8233	N/A	New Facility	N/A	4877	4877			
Radiology Diag	Hospital	4965	N/A	New Facility	N/A	2538	2538			
CT Scan	Hospital	400	N/A	New Facility	N/A	616	616			
Laboratory	Hospital	2186	N/A	New Facility	N/A	2120	2120			
Respiratory Therapy	Hospital	1831	N/A	New Facility	N/A	437	437			
Physical Therapy	Hospital	5131	N/A	New Facility	N/A	0	0			
Occupational Therapy	Hospital	884	N/A	New Facility	N/A	0	0			
Emergency	Hospital	5012	N/A	New Facility	N/A	2910	2910			
Other	Hospital	3610	N/A	New Facility	N/A	6939	6939			
B. Unit/Depart. GSF Sub-Total						40190	40190			
C. Mechanical/ Electrical GSF		4935				1660	1660			
D. Circulation /Structure GSF		N/A				5001	5001			
E. Total GSF		78341				46851	46851			

their allocation. The existing 25 acute beds will be relocated to the replacement facility adjacent to the current campus.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. **Adult Psychiatric Services –**
2. **Alcohol and Drug Treatment for Adolescents (exceeding 28 days) –**
3. **Birthing Center –**
4. **Burn Units –**
5. **Cardiac Catheterization Services –**
6. **Child and Adolescent Psychiatric Services –**
7. **Extracorporeal Lithotripsy –**
8. **Home Health Services –**
9. **Hospice Services –**
10. **Residential Hospice –**
11. **ICF/MR Services –**
12. **Long-term Care Services –**
13. **Magnetic Resonance Imaging (MRI) –**
14. **Mental Health Residential Treatment –**
15. **Neonatal Intensive Care Unit –**
16. **Non-Residential Methadone Treatment Centers –**
17. **Open Heart Surgery –**
18. **Positron Emission Tomography –**
19. **Radiation Therapy/Linear Accelerator –**
20. **Rehabilitation Services –**
21. **Swing Beds –**

This item is not applicable. No new health services will be initiated as a result of the construction of the replacement facility. The health services which are currently offered at the old facility will be part of the replacement facility.

D. Describe the need to change location or replace an existing facility.

The new facility allows for expansion for the future while covering today's needs. The existing structure was built in 1983 and will require expensive upgrades to bring it up to today's standards for Healthcare and building codes. The existing structure has low ceiling heights which are non-conducive to new equipment. Most of the building's mechanical and electrical equipment life span is past its date of replacement. New hospital systems are much more energy efficient and effective for today's hospital standards.

One of the major drawbacks of remodeling the existing facility is the phasing required to complete the remodel. The issues are: departments have to be relocated, areas divided into smaller pieces due to occupancy, and increased general cost due to a longer schedule. Typically, it takes twice as long to

completely remodel an existing facility as it does to construct new. You also have to deal with numerous infection control issues, life safety, and routing of patients and staff.

LCH was built and expanded when the norm was for patients to have lengthy inpatient hospital stays. As healthcare has changed, and with the mandates of healthcare reform, care is moving toward a more outpatient model, making it more important that healthcare facilities provide quick and easy access for patients to find the facility, park, and easily navigate the campus. The health system must prepare for the future by investing in a facility and services that will maximize returns in an increasingly challenging environment in terms of reimbursement models and payment reform.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

This item is not applicable. No such items of major medical equipment or other such equipment will be initiated as a result of the construction of the replacement facility.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1. **Size of site (*in acres*);**
2. **Location of structure on the site;**
3. **Location of the proposed construction; and**
4. **Names of streets, roads or highway that cross or border the site.**

See Attachment 6

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

The new hospital is to be found at the corner of US Highway 51 and Asbury Avenue in Ripley, TN and will be accessible by patients off Asbury Avenue. There are no public transportation routes in the area. The replacement facility is directly adjacent to the existing facility on the same 35 acre parcel of property.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: *DO NOT SUBMIT BLUEPRINTS.* Simple line drawings should be submitted and need not be drawn to scale.

See Attachment 7

V. For a Home Health Agency or Hospice, identify:

1. **Existing service area by County;**
2. **Proposed service area by County;**
3. **A parent or primary service provider;**
4. **Existing branches; and**
5. **Proposed branches.**

The proposed project does not include Home Health or Hospice services and it is therefore Not Applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. **Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.**

   a. **Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.**

   The proposed project helps the Hospital to better accomplish the Five Principles for Achieving Better Health as laid out in the Tennessee State Health Plan: 2014.

   Healthy Lives
   The proposed project will consist of a replacement hospital that is geared towards 21st century healthcare. The old facility was built at a time when the delivery of healthcare was primarily inpatient. The new facility will be state-of-the-art and while inpatient services will be offered the facility will be designed to grow and expand outpatient services and meet the needs of the community where they "live, work and learn."

   Access
   If LCH does not replace its existing facility it is a matter of time before the entire facility will be outmoded and potentially not meet hospital code requirements. The proposed project assures inpatient and outpatient access to the community for decades to come.

In addition, the hospital will continue to offer charity care and participate in TennCare and the Medicare program. It is important to note that the hospital works to ensure care is provided to all patients regardless of income and will continue to do so with the replacement project.

Economic Efficiencies
Building to current healthcare standards will improve efficiencies in operations at the hospital. In addition, by being a rural provider LCH is able to more economically take care of patients locally than having those patients travel to larger tertiary facilities. The delivery of care costs less and is more convenient to the patient if done locally.

Quality of Care
LCH strives to constantly improve its quality of care and patient satisfaction. A new facility will only improve upon both quality and satisfaction.

Workforce.
The number one recruitment tool for healthcare professionals is a new facility. Providers and other healthcare professionals prefer to work in newer facilities. In addition, a replacement will allow LCH to maintain their current staff.

The Criteria and Standards for a replacement hospital include the following:

(a) The applicants should provide plans which include costs for both renovation and relocation, demonstrating the strength and weaknesses of each alternative.

As a critical access hospital, there are few options available to LCH beyond renovation, replacement or the status quo. The current status quo is becoming untenable. The current facility is over thirty years old. The life of the mechanical and electrical equipment is well past its date of replacement. In addition the current facility is not conducive to new equipment and/or technology. For these reasons, the applicant rejects the status quo option.

LCH is then limited to renovation or replacement; this is due primarily to the construction and licensing requirements that are unique to hospitals, i.e. oxygen and vacuum lines in the walls, air handling to achieve negative pressure, lead-lined walls in Radiology. A new facility allows for expansion for the future while covering today's needs. The existing structure will require expensive upgrades to bring it up to today's standards for healthcare and building codes. New hospital systems are much more energy efficient and effective for today's hospital standards and most importantly are tailored towards the outpatient setting. Based on the applicant's experience and concern for investing in an old facility, the option of renovation was rejected.

(b) The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

The below table shows the LCH's existing volumes for the last three years demonstrating the current demand for the proposed replacement hospital. With the replacement, the applicant will increase volume primarily captured from its primary service area. If a new hospital is not built within the next five years the applicant's fears volume will decline and threaten the long-term viability of the hospital.

Table 1: Demonstrate Existing Need

Volume Statistics	2013	2014	2015
DISCHARGES:			
ACUTE	356	281	255
SWINGBED	72	88	117
ER VISITS	11,446	10,065	10,432
SURGERIES	296	164	56
OUTPATIENT VISITS	7,187	7,391	6,441
ANCILLARY UTILIZATION			
RADIOLOGY:			
INPATIENT	815	401	550
OUTPATIENT	15,374	14,705	12218
LABORATORY:			
INPATIENT	3,880	3,262	4,596
OUTPATIENT	44,145	41,891	40,352
PHYSICAL THERAPY:			
INPATIENT	2,235	2,682	2,489
OUTPATIENT	11,974	15,111	12,294

b. Applications that include a Change of Site for a health care institution provide a response to General Criterion and Standards (4) (a-c)

This question is not applicable to this project.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

This project represents a significant step forward in regards to the development of LCH and its ability to provide quality healthcare to the Ripley area. In addition to improvements in quality of care, this project will make it possible for LCH to provide that care efficiently and maximize the benefit to patients and staff alike.

Since 2010 when the hospital was acquired from Baptist Memorial Health Care the long-range plan for the hospital has been for the old facility to be replaced. It is the applicant's desire to right size and maximize the use of the hospital which can only be done with a replacement facility.

3. **Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

The proposed service area is also the current service area of LCH. LCH receives 78% of its patients from Ripley, TN in Lauderdale County. Because LCH is a rural hospital the applicant does not expect the service area to change. The new facility will ensure that LCH does not lose patients in the future and that services will be maintained for future generations.

Please find Attachment 8 for a state map of Tennessee and Lauderdale County.

4. A. **Describe the demographics of the population to be served by this proposal.**

As noted in the table below, the primary service area of LCH is Ripley, TN. Ripley itself had a population of 17,260 as of 2013 and by 2018 the population is expected to decline slightly to 17,015 or a decrease of 1.4%.

Table 2: General Demographics

Ripley, TN (Zip Code 38063)			
	2010 CENSUS	2013 ESTIMATE	2018 FORECAST
Population	17,360	17,260	17,015
Households	6,594	6,560	6,512
Families	4,671	4,648	4,612
Median Age	36.1	36.8	37.7
Median Household Income	$31,743	$33,795	$36,868
Average Household Income	$42,601	$45,375	$49,087
Average Household Size	2.63	2.63	2.61
65 + Population	2,256	2,406	2,774
% 65 + Population	13.1%	13.9%	16.3%

People over the age of 65 are expected to grow from 13.9% of the total population in 2013 to an estimated 16.3% by 2018. Currently, Medicare represents 38% of LCH gross revenue and as the demographics suggest, the 65+ age cohort will continue to be a significant patient base for the hospital.

Table 3: +65 Age Cohort

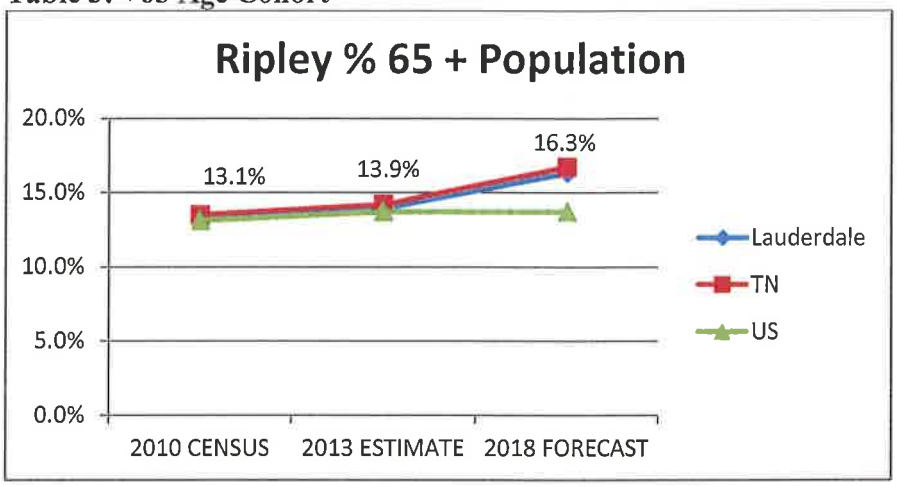

Table 4: Household by Income

Households by Income				
	2013 Estimate		2018 FORECAST	
	Number	Percent	Number	Percent
Less Than $10,000	877	13.40%	845	13.00%
$10,000 - $14,999	640	9.80%	383	5.90%
$15,000 - $19,999	365	5.60%	500	7.70%
$20,000 - $24,999	486	7.40%	362	5.60%
$25,000 - $29,999	471	7.20%	513	7.90%
$30,000 - $34,999	581	8.90%	411	6.30%
$35,000 - $39,999	501	7.60%	645	9.90%
$40,000 - $44,999	229	3.50%	369	5.70%
$45,000 - $49,999	309	4.70%	259	4.00%
$50,000 - $59,999	533	8.10%	550	8.40%
$60,000 - $74,999	519	7.90%	503	7.70%
$75,000 - $99,999	511	7.80%	522	8.00%
$100,000 - $124,999	224	3.40%	287	4.40%
$125,000 - $149,999	82	1.20%	105	1.60%
$150,000 - $199,999	36	0.50%	46	0.70%
$200,000+	196	3.00%	212	3.20%
Total	**6,560**	**100.00%**	**6,512**	**100.00%**

Table 5: Population by Age

Population by Age				
	2013 ESTIMATE		2018 FORECAST	
	Number	Percent	Number	Percent
Age 0-4	1,230	7.10%	1,087	6.40%
Age 5-9	1,262	7.30%	1,157	6.80%
Age 10-14	1,300	7.50%	1,222	7.20%
Age 15-19	1,212	7.00%	1,254	7.40%
Age 20-24	1,115	6.50%	1,171	6.90%
Age 25-29	1,081	6.30%	1,059	6.20%
Age 30-34	1,073	6.20%	1,017	6.00%
Age 35-39	996	5.80%	1,013	6.00%
Age 40-44	1,065	6.20%	944	5.50%
Age 45-49	1,198	6.90%	1,045	6.10%
Age 50-54	1,205	7.00%	1,122	6.60%
Age 55-59	1,095	6.30%	1,117	6.60%
Age 60-64	1,019	5.90%	1,035	6.10%
Age 65-69	815	4.70%	925	5.40%
Age 70-74	580	3.40%	698	4.10%
Age 75-79	417	2.40%	509	3.00%
Age 80-84	282	1.60%	309	1.80%
Age 85+	312	1.80%	333	2.00%
Total	**17,257**	**100.00%**	**17,017**	**100.00%**
Median	**36.8**		**37.7**	

B. **Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.**

LCH treats and is prepared for all special needs. But two special needs are predominant in Lauderdale County and are the ones the applicant concentrates on.

First, Lauderdale County has the second highest unemployment rate in the state and subsequently the county has a large low-income population. The average household income is 26% below the state average. The hospital is accustomed to managing the healthcare of TennCare/Medicaid. According to the TennCare Enrollment Report, as of November 15th there were 8,093 recipients of TennCare in Lauderdale County. Last year (2015), LCH topped $4,000,000 in uncompensated care provided without reimbursement. The proposed hospital's

replacement facility will continue to have contractual agreements with TennCare/Medicaid and continue to serve the needs of underserved and indigent of Lauderdale County.

The second special need is the 65+ age group. People over the age of 65 are expected to grow from 13.9% of the total population in 2013 to an estimated 16.3% by 2018. Currently, Medicare represents 38% of LCH gross revenue and as the demographics suggest, the 65+ age cohort will continue to be a significant patient base for the hospital. As a result, LCH will continue to be an active utilizer of Medicare to serve this age group.

Medicare, TennCare/Medicaid along with other insurance companies will continue to make sure that all needs within the service area population, including health disparities, are met.

5. **Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.**

There are no institutions similar to LCH in the service area and therefore this is not applicable.

6. **Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.**

The below Table shows utilization data for the last three years projected through 2021.

Table 6: Utilization

In/Outpatient	Actual			Projected					
Statistic	2013	2014	2015	2016	2017	2018	2019	2020	2021
Inpatient									
Acute Days	1,392	1,167	979	987	1,017	1,098	1,142	1,176	1,200
Swing Day	1,006	1,179	1,210	1,195	1,230	1,329	1,382	1,423	1,452
Outpatient									
Surgeries	296	164	56	44	45	49	51	52	53
ER Visists	11,446	10,065	10,432	10,453	10,663	10,876	11,093	11,315	11,541
Radiology Proc	15,374	14,705	12,218	12,519	12,895	13,926	14,483	14,918	15,216
Lab Tests	44,145	41,891	40,352	44,822	46,167	49,860	51,855	53,411	54,479

The methodology for the projection of the key drivers of LCH involves several different factors. First, the applicant built a baseline trend based on prior year results; LCH then projects the baseline forward with percentage changes in growth. Generally, the hospital assumes 2% volume growth unless special circumstances exist. In the case of the construction of a replacement facility volume growth is 8% in 2018 and 4% in 2019. The volume growth rates following new construction are conservative compared to the 7th Annual *Rural Hospital Replacement Facility* Study prepared in 2011 by Stroudwater Associates (see Attachment 9). The Stroudwater Study has shown that some Critical Access Hospitals have as much as a 40% volume growth in the first year following a replacement.

The applicant assumes that the construction period for the new facility will span 2017 and 2018 fiscal years. As a result, 2018 and 2019 have the increased volume growth mentioned above.

Table 7: Detailed Utilization Percent Increase by Projected Year

In/Outpatient	Projected Increase per Year					
Statistic	2016	2017	2018	2019	2020	2021
Inpatient						
Acute Days	1%	3%	8%	4%	3%	2%
Swing Day	-1%	3%	8%	4%	3%	2%
Outpatient						
Surgeries	-21%	2%	9%	4%	2%	2%
ER Visits	0%	2%	2%	2%	2%	2%
Radiology Proc	2%	3%	8%	4%	3%	2%
Lab Tests	11%	3%	8%	4%	3%	2%

ECONOMIC FEASIBILITY

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

   - **All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)**

     Confirmed – application fee is shown on Line F of the Project Costs Chart.

   - **The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.**

     This section is Not Applicable – existing equipment will be relocated to the new facility.

   - **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

     Not Applicable. All existing equipment will be relocated to the new facility.

   - **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

     Please See Attachment 10

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	1,145,147
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	0
3.	Acquisition of Site	0
4.	Preparation of Site	1,290,053
5.	Construction Costs	14,023,308
6.	Contingency Fund	1,190,952
7.	Fixed Equipment (Not included in Construction Contract)	0
8.	Moveable Equipment (List all equipment over $50,000)	0
9.	Other (Specify)	0
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	0
2.	Building only	0
3.	Land only	0
4.	Equipment (Specify)	0
5.	Other (Specify)	0
C.	Financing Costs and Fees:	
1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve for One Year's Debt Service	2,350,000
4.	Other (Specify)	0
D.	Estimated Project Cost (A+B+C)	19,999,460
E.	CON Filing Fee	44,999
F.	Total Estimated Project Cost (D+E)	20,044,459
	TOTAL	20,044,459

2. Identify the funding sources for this project

Please check the applicable items below and briefly summarize how the project will be financed. (Documentation of the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

__ A. Commercial Loan—Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

__ B. Tax-exempt Bonds—Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General Obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants—Notification of intent form for grant application or notice of grant award;

__ E. Cash Reserves—Appropriate documentation from Chief Financial Officer

X F. Other—Identify and document funding from all other sources.

The total project cost for the new hospital facility will be approximately $23 million. The project will be funded from two sources.

1. New Market Tax Credits (NMTC) will provide $3 million (or approximately 23%) of the total project cost. This investment will be provided through CHHS in the form of a subordinated, interest-only promissory note with a term of no less than 7 years at an interest rate of 2.5% to 3.0% range. A January 8, 2016 letter from Benjamin Cirka, Executive Director, CHHS is included at Attachment 11.
2. The remaining $20 million will be provided by CBC Real Estate Group, LLC (CBC). CBC will act as the Project Developer and will arrange for this funding in cooperation with a designated real estate investment trust (REIT). The applicant has engage CFG Capital Markets, LLC, as its financial advisor to originate and structure this aspect of the lease transaction. A January 8, 2016 letter from Samer Tahboub, Director, CFG, is included in Attachment 11.

3. **Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

This project's $298.60 cost per SF for new construction is based on research conducted by LCH's architect and builder. The construction cost of $298.60 is higher than the median costs for hospital construction projects submitted to HSDA for the years 2012-2014; however the pricing completed by LCH's architect and builder are more current and up to date. Even with the 2012-2014 data the proposed project construction is only slightly higher than HSDA's 3rd Quartile (See table below).

Table 8: HSDA Construction Cost

	Cost per SF			
	1st Quartile	Median	3rd Quartile	Lauderdale Community Hospital
New Hospital Construction	224.09	259.66	296.52	298.60

4. **Complete historical and projected data charts on the following pages**

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in OCTOBER (Month).

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Specify unit of measure)	2,398	2,347	2,189
B. Revenue from Services to Patients			
1. Inpatient Services	$6,862,824	$5,450,236	$5,789,102
2. Outpatient Services	13,203,736	15,779,429	14,752,755
3. Emergency Services	18,607,677	18,126,238	20,930,085
4. Other Operating Revenue (Specify) Cafeteria, Med Records,MCR EHR, Grant Income	522,385	615,349	500,784
Gross Operating Revenue	$39,196,622	$39,971,252	$41,972,726
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$19,817,700	$20,531,497	$23,976,735
2. Provision for Charity Care	837,130	176,674	274,237
3. Provisions for Bad Debt	3,415,875	3,535,255	2,843,619
Total Deductions	$24,070,705	$24,243,426	$27,094,591
NET OPERATING REVENUE	$15,125,917	$15,727,826	$14,878,135
D. Operating Expenses			
1. Salaries and Wages	$5,884,252	$6,141,906	$6,244,450
2. Physician's Salaries and Wages	150,611	150,412	43,187
3. Supplies	1,250,825	1,301,259	1,279,405
4. Taxes	152,790	134,160	120,053
5. Depreciation	915,401	989,069	849,949
6. Rent	0	0	0
7. Interest, other than Capital	80,431	69,960	103,759
8. Other Expenses (Specify) Benefits,Med Specialist Fees,Purchased Services,MCR	5,575,183	5,412,387	5,785,483
Total Operating Expenses	$14,804,610	$14,226,173	$14,426,286
E. Other Revenue (Expenses) – Net (Specify)	$0	$0	$0
NET OPERATING INCOME (LOSS)	$321,307	$1,501,653	$451,849
F. Capital Expenditures			
1. Retirement of Principal	$435,016	$605,887	$1,002,827
2. Interest	322,017	318,794	122,062
Total Capital Expenditures	$757,033	$924,681	$1,124,890
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$(435,726)	$576,972	$(673,041)

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in October (Month).

		Year 2018	Year 2019
A.	Utilization Data (Specify unit of measure)	2427	2524
B.	Revenue from Services to Patients		
1.	Inpatient Services	$6,940,971	$7,435,168
2.	Outpatient Services	34,395,985	36,642,245
3.	Emergency Services	8,572,030	9,005,774
4.	Other Operating Revenue (Specify)	0	0
	Gross Operating Revenue	$49,908,986	$53,083,188
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$27,499,852	$29,355,003
2.	Provision for Charity Care	330,028	351,017
3.	Provisions for Bad Debt	4,940,990	5,255,236
	Total Deductions	$32,770,870	$34,961,256
NET OPERATING REVENUE		$17,138,116	$18,121,932
D.	Operating Expenses		
1.	Salaries and Wages	$5,530,704	$5,710,700
2.	Physician's Salaries and Wages	0	0
3.	Supplies	1,758,823	1,857,205
4.	Taxes	0	0
5.	Depreciation	1,277,778	1,277,778
6.	Rent	0	0
7.	Interest, other than Capital	42,674	42,674
8.	Other Expenses (Specify) Purch Svcs; Mgmt Fees, Emp Benefits; Other Operating	6,284,743	6,610,015
	Total Operating Expenses	$14,894,722	$15,498,372
E.	Other Revenue (Expenses) -- Net (Specify)	$448,828	$448,828
NET OPERATING INCOME (LOSS)		$2,692,222	$3,072,388
F.	Capital Expenditures		
1.	Retirement of Principal	$638,677	$636,573
2.	Interest	2,045,333	1,990,877
	Total Capital Expenditures	$2,684,010	$2,627,450
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$8,212	$444,938

5. **Please identify the project's average gross charge, average deduction from operating revenue and average net charge.**

Table 9: Average Charges, Deductions and Net

Average Gross Charges, Deductions and Net	Actual			Projected	
	2013	2014	2015	2018	2019
Patient Days	2,398	2,347	2,189	2,427	2,524
Gross Charges	39,196,622	39,971,252	41,972,726	49,908,986	53,083,188
Deductions	24,070,705	24,243,426	27,094,591	32,770,870	34,961,256
Net Patient Revenue	15,125,917	15,727,826	14,878,135	17,138,116	18,121,932
Average Cost					
Gross Charges	16,346	17,031	19,174	20,564	21,031
Deductions	10,038	10,330	12,378	13,503	13,852
Net Patient Revenue	6,308	6,701	6,797	7,061	7,180

6. **A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

Since the proposed project does not involve the implementation of new services or additional beds, LCH does not anticipate an increase in charges other than normal inflationary increases of 3 percent and cost report adjustments that occur annually.

Please see Attachment 12 for LCH's current allowable reimbursement letters from the hospital's Medicare Intermediary.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

There are no similar facilities to LCH in the service area or adjoining service areas. LCH is a Critical Access Hospital and is reimbursed based upon costs that are adjusted annually by Medicare. In addition, there are no new proposed charges with this application.

7. **Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.**

As indicated in the Utilization Table and the Projected Data Chart, utilization rates will increase with a replacement facility. A replacement facility will mean a more efficiently designed configuration which will greatly enhance effectiveness of staff and providers. Furthermore, more efficient mechanical systems such as heating and cooling will

dramatically reduce utility costs.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

LCH is currently running at a positive cash flow as of Fiscal Year 2015; this trend is expected to continue into 2016. Current cash reserves and anticipated positive cash flow in Fiscal Year 2016 is expected to cover any temporary cash flow issues during construction, as can be seen below.

Table 10: Cash Flow chart

	Actual			Projected					
Sources & Uses of Cash:	2013	2014	2015	2016	2017	2018	2019	2020	2021
Sources:									
Cash from Operations	914,692	2,171,933	1,179,732	2,103,264	1,908,854	1,924,668	2,359,289	2,647,420	2,705,475
Other	4,399,931	1,083,551	1,997,881	5,986,974	17,358,483	111,737	320,043	169,147	122,099
Total Sources	5,314,623	3,255,484	3,177,613	8,090,238	19,267,337	2,036,405	2,679,331	2,816,567	2,827,574
Uses:									
Total Uses	5,355,765	3,542,556	3,154,441	6,559,667	18,266,046	1,328,742	997,977	916,775	1,419,854
Net Source or Use of Cash	(41,142)	(287,072)	23,172	1,530,571	1,001,291	707,663	1,681,354	1,899,792	1,407,720
Beginning Cash	346,953	305,811	18,739	41,911	1,572,482	2,573,773	3,281,437	4,962,791	6,862,583
Ending Cash	$305,811	$18,739	$41,911	$1,572,482	$2,573,773	$3,281,437	$4,962,791	$6,862,583	$8,270,303

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

The replacement facility for LCH will continue to participate in state and federal programs including Medicare and TennCare/Medicaid. Medicare is 37.73% of utilization and Medicaid is 22.07%. The hospital also provides over $4 million in indigent care annually. The applicant does not foresee a significant change in its current payor mix as a result of the proposed hospital replacement.

Please see below Table.

Table 11: Projected Payor Mix

Projected Payor Mix	Projected Revenue in 2018	% of Total
Medicare	18,830,535	37.73%
Medicaid	11,013,951	22.07%
Blue Cross	4,752,356	9.52%
Commercial/Oth	10,939,800	21.92%
Self-Pay	4,372,344	8.76%
	49,908,986	100.00%

10. **Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.**

See Attachment13

11. **Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:**

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

As a critical access hospital, there are few options available to LCH beyond renovation, replacement or the status quo. The current status quo is becoming untenable. The current facility is over thirty years old. The life of the mechanical and electrical equipment is well past its date of replacement. In addition the current facility is not conducive to new equipment and/or technology. For these reasons, the applicant rejects the status quo option.

LCH is then limited to renovation or replacement; this is due primarily to the construction and licensing requirements that are unique to hospitals, i.e. oxygen and vacuum lines in the walls, air handling to achieve negative pressure, lead-lined walls in Radiology). A new facility allows for expansion for the future while covering today's needs. The existing structure will require expensive upgrades to

bring it up to today's standards for healthcare and building codes. New hospital systems are much more energy efficient and effective for today's hospital standards and most importantly are tailored towards the outpatient setting. Based on the applicant's experience and concern for investing in an old facility, the option of renovation was rejected.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

The applicant considered alternatives to new construction and determined that construction of a new facility with modern, state-of-the-art patient rooms was the optimal choice, as discussed above. A full renovation of a 30 year old facility is not cost-effective and would constitute a poor investment that will not meet the health needs of the community for the coming decades.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

   As an existing provider of healthcare services, LCH has in place contractual and working relationships with existing healthcare providers within its service area. The following are existing agreements:

Amerigroup Community Care
Arkansas Northeastern College
Baptist College of Health Sciences
Baptist Health Services Group of the Mid-South Inc.
Baptist Memorial Hospital-Tipton
BlueCross BlueShield of Tennessee
CIGNA HealthCare of Tennessee, Inc
Cigna-HealthSpring
Community Health Alliance
Concorde Career College
DNV Healthcare, Inc
Dyersburg State Community College
Florida Agency for Healthcare Administration
Jackson State Community College
Jackson-Madison County General Hospital
Lauderdale County Ambulance Authority
Le Bonheur Children's Hospital Comprehensive Regional Pediatric Center
Le Bonheur Children's Medical Center
MultiPlan, Inc
Prime Health Services, Inc.
Tennessee College of Applied Technology-Ripley
Tennessee Hospital Association
UnitedHealthcare of Tennessee, Inc
University of Memphis Loewenberg School of Nursing
US Department of Health and Human Services
Vanderbilt University Medical Center
Windsor Health Plan, Inc

The facility currently contracts with several managed care organizations and expects those relationships to continue.

BlueCare	PHCS
BluePreferred	Mail Handlers Benefit Plan
Blue Select	Correctional Medical Services
Blue Cross 65	Windsor Extra
Cover TN	Blue Advantage Plus HMO
Access TN	Humana Gold Plus Medicare HMO
Cover Kids	Medicare Advantra Freedom PFFS
AARP Health Options	Unison Medicare Advantage
Aetna PPO	Champus/Tricare
Coventry Healthcare	United Health Care Community Plan
GEHA	United Healthcare
Humana	United Healthcare Medicare HMO
Ironworkers #167	TennCare Select
Mutual of Omaha	

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

The effect of this project on the healthcare environment in Lauderdale County is that the quality and efficiency of local healthcare will increase. Replacing a 30 year old facility with a new modern state-of-the-art facility in rural Ripley, TN will ensure that the community can receive care at home in their local community. It is costly for the families to have to travel to larger tertiary facilities for healthcare and a new facility will ensure access to local healthcare for decades to come.

In addition, a replacement facility will assist in the recruitment of physicians. As noted throughout the application, there are no existing providers in the same service area as this project and minimal to no instances of duplication or competition from this proposal.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

The current staffing patterns indicate 107 Full Time Employees with 66 providing direct patient care, although all employees meet/serve the patient population in some way. The number of patient care services provided will not change with the replacement facility. The Applicant currently and shall continue into the future to pay wages to its patient care givers that are consistent with the prevailing wages offered to similar employees in its service area. See table below for wage rate comparison.

Table 12: FTEs and Wage Rate Comparison

Department	FTEs	LCH Avg Wage Rate	Prevailing Wage Rate- TN
Administration	15.05	18.04	17.09
Dietary	6.03	13.83	9.54
Emergency	14.16	29.97	27.1
HIM	4.81	24.32	20.39
Housekeeping	5.51	13.48	14.88
Laboratory	8.55	24.33	18.07
Med/Surg	22.38	25.47	21.32
Other	0.13	32.10	27.48
Pharmacy	5.40	59.43	58.89
Plant Ops	2.98	20.43	28.75
Radiology	8.13	29.58	24.45
Surgery	0.22	42.89	24.42
Therapies	14.54	33.44	25.55
Average	107.89	26.52	27.48

4. **Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.**

   The Applicant has qualified, licensed professional staff employed and/or contracted to deliver high quality care as required by the TN Department of Health. It is anticipated all current employees will transfer over to the new facility.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.***

   The Applicant has reviewed, understands and adheres to all licensing certifications as required by the State of Tennessee for medical/clinical staff. These would include without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education. The Applicant continues to be certified and accredited through DNV, CLIA, JCAHO, TN DEPT OF HEALTH, AMERICAN COLLEGE OF RADIOLOGY, and TN BOARD OF PHARMACY

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).**

The Applicant has a Clinical Affiliation agreement with TN College of Applied Technology – Ripley. The purpose of this agreement is for the Applicant to provide clinical experience to students enrolled in the Four Rivers Regional Practical Nursing program.

The Applicant has a Clinical Affiliation Agreement with Jackson State Community College. The purpose of this agreement is for the Applicant to provide clinical experience to students enrolled in the Physical Therapist Assistant program of the college.

The Applicant has a Pediatric Training program Agreement with LeBonheur Children's Hospital. The purpose of this agreement is for Applicant's staff to have access to continuing education in order to maintain and update their skills in recognizing and stabilizing pediatric emergencies.

The Applicant has an agreement with Zaidi & Associates to assist in Clinical Internships available through this local physician provider.

7. (a) **Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

The Applicant is replacing its existing hospital. The Applicant is familiar with and understands all the licensure requirements of the Department of Health and all other Tennessee regulatory agencies and applicable Medicare requirements.

(b) **Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.**

Licensure: Board for Licensing Health Care Facilities
State of Tennessee Department of Health

Accreditation: Certificate of Accreditation by DNV GL – Healthcare.
Continued deemed status in the Medicare program.

(c) **If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.**

The existing facility's License is in good standing with the State of Tennessee Department of Health. A copy of the current facility's Hospital License is attached. See Attachment 14.

The existing facility's Certificate of Accreditation is in good standing with DNV GL – Healthcare. A copy of the Certificate of Accreditation is attached. See Attachment 14.

(d) **For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.**

The existing facility was cited in the last DNV Reaccreditation survey on July 28 – 29, 2015. The Survey Report and Corrective Action Plan Submittal Form are attached; See attachment 15.

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Not applicable at this time.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project**

Not applicable at this time.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

Applicant will provide such data as needed by the State of Tennessee.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Patrick Maddox, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal to-wit:

January 10, 2016

Helen Curl

Subscribed and sworn to before me this 11th day of January, 2016.

Notary Public

My commission expires February 15, 2016.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: CAH Acquisition Company 11, LLC, a Hospital owned by: HMC/CAH Consolidated, Inc. with an ownership type of LLC and to be managed by: Rural Community Hospitals of America, LLC intends to file an application for a Certificate of Need for CAH Acquisition Company 11, LLC, d/b/a Lauderdale Community Hospital, is located at 326 Asbury Avenue, Ripley, Tennessee and has a growing inpatient census averaging around 8.5 patients per day. Lauderdale Community Hospital is proposing to build a new 25 bed facility on its current campus consisting of 46,851 square feet at an expected construction cost (including site preparation work) of $19,999,460. The new hospital will replace the existing 33 year old facility that is outdated and does not provide the efficiencies that a new facility will provide. The new hospital will continue to offer the same services currently provided, which include acute, emergency, swingbed and outpatient services.

The anticipated date of filing the application is: January 15, 2016.

The contact person for this project is Tammie Hardy, CEO, who may be reached at: Lauderdale Community Hospital, 326 Asbury Avenue, Ripley, TN 38063, 731-221-2200.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted.

Written requests for hearing should be sent to:
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

PATRICK MADDOX
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

My Commission Expires 02/15/2016

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CELEBRATING 175 YEARS

Luttrell invited to State of the Union

Criminal justice work earns seat with first lady

By Michael Collins
mcollins2@gannett.com
202-408-2711

WASHINGTON — Shelby County Mayor Mark Luttrell's work on criminal justice reform has landed him an unusual invitation: a seat at President Barack Obama's State of the Union address.

Luttrell, a Republican, will be seated in first lady Michelle Obama's guest box when the president delivers his final State of the Union to a joint session of Congress on Tuesday night.

The White House said Luttrell and other invited guests were chosen because they represent the progress that has been made since Obama delivered his first State of the Union seven years ago.

"The guests personify President Obama's time in office and, most importantly, they represent who we are as Americans: inclusive and compassionate, innovative and courageous," the White House said in a statement.

Luttrell was chosen because, throughout his career in public service, he has built partnerships with local, state and federal agencies, and because of his focus on criminal justice reform, the White House said.

Michelle Obama

Mark Luttrell

Luttrell said the White House extended the invitation about a week ago. He said he has never attended a State of the Union address.

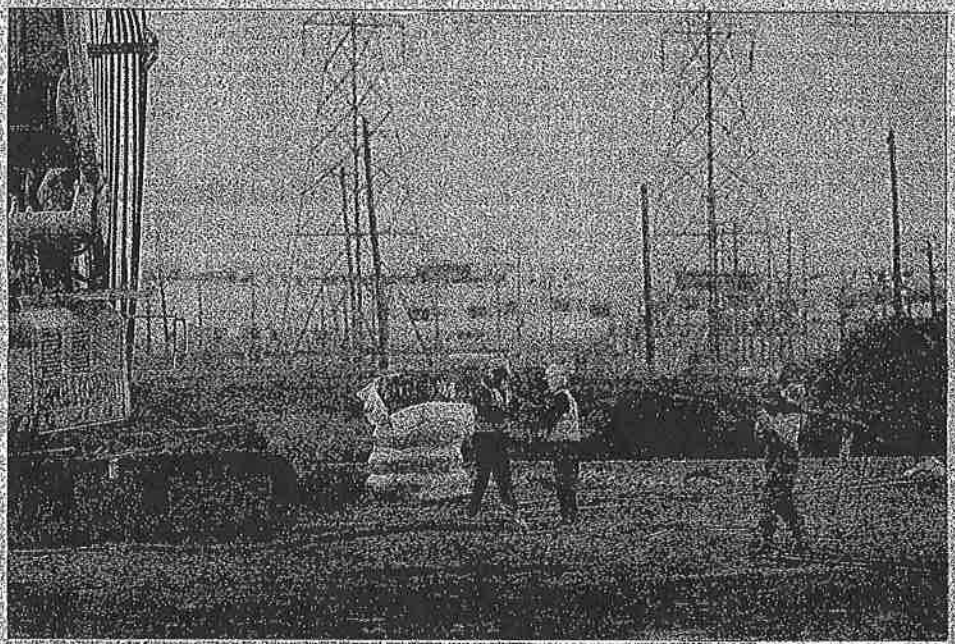
"It's something I'm looking forward to," he said. "I think it's an opportunity to really highlight some really critical needs as it relates to the criminal justice system and re-incarceration and re-entry."

As mayor, Luttrell helped create specialty courts to handle mental health and veterans' cases and provide resources for rehabilitation instead of incarceration. Shelby County's new mental health court launched just this month.

The White House also praised Luttrell's efforts to reduce recidivism by streamlining and pooling resources to give offenders the

See LUTTRELL, 2A

FROM COAL TO GAS



BRAD SCHMIDT/THE COMMERCIAL APPEAL

Construction continues on the 75-acre site at Frank C. Pidgeon Industrial Park where the Tennessee Valley Authority is building a $975 million natural gas-fired electrical generating plant to replace the Allen Fossil Plant. The new facility is expected to greatly reduce emissions and increase efficiency.

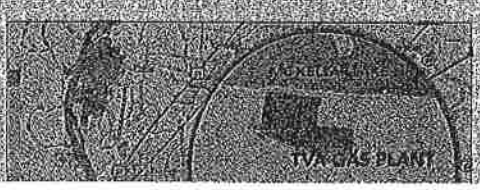
TVA building huge plant to cut pollution, boost efficiency

By Tom Charlier
tcharlier@commercialappeal.com
901-529-2572

In the far southwestern corner of Memphis, in the shadow of the nearly 60-year-old Allen Fossil Plant, dump trucks maneuver around towering drill rigs and

plant to replace the aging coal-burning facility just to the north. When it's finished in mid-2018, the plant will produce enough power for 580,000 homes — twice the number that exist in Memphis.

"We are on schedule and on budget," said Dan Tibbs, who is



Public backs Obama on guns

Survey finds support for restrictions

By Christopher Ingraham
Washington Post

President Barack Obama rolled out a package of executive actions on guns last week. The changes included clarifying rules meant to broaden the use of background checks by private sellers, allocating money for mental health treatment, and adding more staff at the FBI and the Bureau of Alcohol, Tobacco, Firearms and Explosives to help enforce existing regulations.

The changes were modest in scope — experts and even the NRA agreed that their overall impact would be small. That didn't stop Obama's critics from fiercely denouncing the proposals. But the president predicted the public would be on his side. The actions would be supported by an "overwhelming majority of the American people, including gun owners," he said on Monday.

As it turns out, he was right.

A new CNN-ORC survey of 1,000 Americans finds that the public supports Obama's plan by a

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ALL INTERESTED BIDDERS

The Shelby County Board of Education will accept written Request for Proposals for Instructional Tools.

Visit our website for additional information: www.scsk12.org-Departments, Procurement Services link, click on Bids & RFPs.

Questions concerning proposals should be addressed to Procurement Services at (901) 416-5376.

Thank you for your interest and responses.

ALL INTERESTED BIDDERS

The Shelby County Board of Education will accept written Request for Proposals for Development of Standard Operating Procedures.

Visit our website for additional information: www.scsk12.org-Departments, Procurement Services link, click on Bids & RFPs.

Questions concerning proposals should be addressed to Procurement Services at (901) 416-5401.

Thank you for your interest and responses.

Legal Notices

Public Notice

The Memphis Housing Authority will present its FY 2017 and Annual Year Plan Draft for review and comment. The plan outlines the MHA's policies and procedures for the coming fiscal year as well as the agency's goals over the next five years. These plans are required under the Quality Housing and Work Act, passed by Congress in 1998 to enact public housing reform. The plans and all attachments are available for review and comments January 14-February 29, 2016.

Copies of the plan are available at:

Human Resources Department
Memphis Housing Authority
700 Adams
Memphis, TN 38105

Benjamin Hooks Central Library
3030 Poplar
Memphis, TN 38111

The Memphis Housing Authority will hold a public hearing on the plan Thursday, March 10, 2016. The hearing will be held in the Memphis housing Authority's Boardroom on the 2nd Floor.

Formal written comments on the plans and its attachments are welcome throughout the comment period.

Please submit all comments to comments to:
Memphis Housing Authority
Attention:
Executive Director
PHA Annual and Five Years Plans
700 Adams Avenue
Memphis, TN 38105

Legal Notices

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that: CAH Acquisition Company 11, LLC, a Hospital owned by: HMC/CAH Consolidated, Inc. with an ownership type of LLC and to be managed by: Rural Community Hospitals of America, LLC intends to file an application for a Certificate of Need for CAH Acquisition Company 11, LLC, d/b/a Lauderdale Community Hospital, is located at 326 Asbury Avenue, Ripley, Tennessee and has a growing inpatient census averaging around 5.5 patients per day. Lauderdale Community Hospital is proposing to build a new 25 bed facility on its current campus consisting of 48,851 square feet at an expected construction cost (including site preparation work) of $19,999,460. The new hospital will replace the existing 33 year old facility that is outdated and does not provide the efficiencies that a new facility will provide. The new hospital will continue to offer the same services currently provided, which include acute, emergency, swingbed and outpatient services.

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502 Deaderick Street
Nashville, Tennessee 37243

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SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on February 25, 2016 on or about 10:00AM local time, at the Auction.com Room, Comfort Inn Downtown, 100 N. Front Street, Memphis, Tennessee, conducted by the Substitute Trustee as identified and set forth herein below, pursuant to Deed of Trust executed by CARLA O. HARRIS AND WILLIAM HARRIS, to DENNIE R. MARSHALL, Trustee, on May 22, 2003, as Instrument No. 3104698 in the real property records of Shelby County Register's Office, Tennessee and re-filed as Instrument No. 12019309 in the real property records of Shelby County Register's Office, Tennessee.

Owner of Debt: BANK OF AMERICA, N.A.

The following real estate located in Shelby County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record:

LOT 485, SECTION "B", GRACELAND SUBDIVISION, AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 20, PAGE 35, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY.

Tax ID: 07809700000210

Current Owner(s) of Property: CARLA O. HARRIS AND WILLIAM HARRIS

The street address of the above described property is believed to be 1394 BONNIE DRIVE, MEMPHIS, TN 38116, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO OCCUPANT(S) RIGHTS IN POSSESSION.

THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE. IF THE SALE IS SET ASIDE FOR ANY REASON, THE PURCHASER AT THE SALE SHALL BE ENTITLED ONLY TO A RETURN OF THE DEPOSIT PAID. THE PURCHASER SHALL HAVE NO FURTHER RECOURSE AGAINST THE GRANTOR, THE GRANTEE, OR THE TRUSTEE.

OTHER INTERESTED PARTIES: CAPITAL ONE AUTO FINANCE AND METHODIST LEBONHEUR HEALTHCARE AND A&A FINANCIAL LLC

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

If applicable, the notice requirements of T.C.A. 35-5-117 have been met.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If the U.S. Department of Treasury/IRS, the State of Tennessee Department of Revenue, or the State of Tennessee Department of Labor or Workforce Development are listed as Interested Parties in the advertisement, then the Notice of this foreclosure is being given to them and the Sale will be subject to the applicable governmental entities' right to redeem the property as required by 26 U.S.C. 7425 and T.C.A. §67-1-1433.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time. If the sale is set aside for any reason, the Purchaser at the sale shall be entitled only to a return of the deposit paid. The Purchaser shall have no further recourse against the Mortgagor, the Mortgagee or the Mortgagee's attorney.

MWZM File No. 15-004147-670
JASON S. MANGRUM,
J.P. SELLERS, LORI LIANE LONG,
JOHN R. ROAN, Substitute Trustee(s)
PREMIER BUILDING, SUITE 404
5217 MARYLAND WAY
BRENTWOOD, TENNESSEE 37027
PHONE: (615) 238-3630
EMAIL: TNSALES@MWZMLAW.COM

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DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.

2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period* of *validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.

N/A

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): 4/27/16

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	30	5/27/16
2. Construction documents approved by the Tennessee Department of Health	60	6/26/16
3. Construction contract signed	30	5/27/16
4. Building permit secured	45	6/11/16
5. Site preparation completed	60	6/26/16
6. Building construction commenced	60	6/26/16
7. Construction 40% complete	200	11/13/16
8. Construction 80% complete	365	4/27/17
9. Construction 100% complete (approved for occupancy	425	6/25/17
10. *Issuance of license		
11. *Initiation of service		
12. Final Architectural Certification of Payment	500	9/8/17
13. Final Project Report Form (HF0055)	500	9/8/17

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF Missouri

COUNTY OF Jackson

Trent Skaggs, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Trent Skaggs Exec VP
SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of January (Month), 2016 (Year) a Notary Public in and for the County/State of Jackson County, Missouri.

Linda K. Way
Notary Public - Notary Seal
STATE OF MISSOURI
Jackson County
My Commission Expires: Nov. 17, 2018
Commission #14444354

Linda K. Way
NOTARY PUBLIC

My commission expires November 17 (Month/Day), 2018 (Year).

List of Tables

List of Attachments

Attachment 1	Company Agreement and Certificate of Corporate Existence	Section A, Item 3
Attachment 2	Ownership Structure	Section A, Item 4
Attachment 3	Management Agreement	Section A, Item 5
Attachment 4	Deed of Trust	Section A, Item 6
Attachment 5	Existing MCO's and BHO's	Section A, Item 13
Attachment 6	Plot Plan	Section B, Item III (A)
Attachment 7	Floor Plan	Section B, Item IV
Attachment 8	Map of Proposed Service Area	Section C, Need, Item 3
Attachment 9	7th Annual Rural Hospital Replacement Facility Study *How Replacement Facilities Impact Operations* Stroudwater Associates	Section C, Need, Item 6
Attachment 10	Project Cost Documentation	Section C, Economic Feasibility, Item 1
Attachment 11	Funding Documentation	Section C, Economic Feasibility, Item 2
Attachment 12	Medicare Rate Letters	Section C, Economic Feasibility, Item 6A
Attachment 13	Current Financial Statements and Most Recent Audited Financials	Section C, Economic Feasibility, Item 10
Attachment 14	Facility License	Section C, Orderly Development of Healthcare, Item 7 (c)
Attachment 15	Most Recent Certification of Licensure with any Deficiencies and subsequent Action Plans	Section C, Orderly Development of Healthcare, Item 7 (d)

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 1

Section A, Item 3

Company Agreement and Certificate of Corporate Existence

FIRST AMENDED AND RESTATED LIMITED LIABILITY COMPANY AGREEMENT

OF

CAH ACQUISITION COMPANY 11, LLC

THIS FIRST AMENDED AND RESTATED LIMITED LIABILITY COMPANY AGREEMENT (this "Agreement"), is made as of the 17th day of December, 2013, by CAH ACQUISITION COMPANY 11, LLC, a Delaware limited liability company (the "Company"), and HMC/CAH CONSOLIDATED, INC., a Delaware corporation (the "Member").

RECITAL

A. The Member has caused the Company to be formed as a limited liability company under the Delaware Limited Liability Company Act.

B. The Member desires to adopt this Agreement as the limited liability company agreement of the Company.

AGREEMENT

In consideration of the premises and the agreements contained herein, the undersigned Member declares and agrees as follows:

ARTICLE I - DEFINITIONS

1.1 **Terms Defined Herein.** As used herein, the following terms have the following meanings:

"Act" means the Delaware Limited Liability Company Act, as amended from time to time.

"Agreement" means the First Amended Limited Liability Company Agreement of the Company as amended from time to time.

"Available Cash" means the aggregate amount of cash on hand or in bank, money market or similar accounts of the Company as of the end of each fiscal quarter derived from any source (other than capital contributions and Liquidation Proceeds) that the Member determines is available for distribution to the Member after taking into account any amount required or appropriate to maintain a reasonable amount of Reserves.

"Capital Account" means the account established and maintained by the Company for the Member and any Transferee pursuant to Section 3.3.

"Certificate" means the Certificate of Formation of the Company filed with the Delaware Secretary of State, as amended from time to time.

"Code" means the Internal Revenue Code of 1986, as amended from time to time, or the corresponding provisions of future federal tax laws.

"Company" means CAH Acquisition Company 11, LLC, a Delaware limited liability company, that is authorized to transact business in the State of Tennessee. The Company conducts its business in Ripley, Tennessee.

"Credits" means all tax credits allowed by the Code with respect to activities of the Company or the Property.

"Distributions" mean any distributions of Available Cash, dividends, interest and other cash payments with respect to a Member's Interest, and any non-cash distributions in respect to a Member's Interest, including without limitation all other or additional Interests or other securities or property (other than cash) distributed by way of dividend or distribution in respect of a Member's Interest (i) by way of split, spin-off, split-up, recapitalization, reclassification, combination of interest, or similar rearrangement or (ii) by reason of any liquidation consolidation, merger, exchange, exchange offers, conveyance of assets, exercise of options, contribution of capital, liquidation or similar reorganization.

Economic Interest" shall mean a Member's or the owner of Economic Interest share of one or more of the Company's net profits, net losses, and Distributions of the Company's assets pursuant to this Agreement and the Act, but shall not include any other rights of a Member, including, without limitation, the right to vote or participate in the management, or except as provided in the Act, any right to information concerning the business and affairs of Company.

"Fair Value" of an asset means its fair market value.

"Income" and "Loss" mean, respectively, for each fiscal year or other period, an amount equal to the Company's taxable income or loss for such year or period, determined in accordance with the Code.

"Interest" shall mean a Member's entire interest in the Company including the Member's share of one or more of the Company's Income and Loss, and Distributions, the right to vote on or participate in the management of the Company, and the right to receive information concerning the business and affairs, of the Company, all pursuant to this Agreement and the Act.

"Lender" means Health Acquisition Capital, LLC, a West Virginia limited liability company.

"Liquidation Proceeds" means all Property at the time of liquidation of the Company and all proceeds thereof.

"Majority Interest" shall mean one or more Percentage Interests of Members which taken together exceed fifty percent (50%) of the aggregate of all Percentage Interests.

"Member" means HMC/CAH Consolidated, Inc. or any successor-in-interest, who becomes a Member as provided in this Agreement, and any other Person who becomes a Member, as provided in the Operating Agreement.

'Percentage Interest" shall mean the percentage of a Member set forth opposite the name of such Member under the column "Percentage Interest" in Exhibit A, as such percentage may be adjusted from time to time pursuant to the terms of this Agreement.

"Person" means any individual, partnership, limited liability company, Company, cooperative, trust or other entity.

"Property" means all properties and assets that the Company may own or otherwise have an interest in from time to time.

"Reserves" means amounts set aside from time to time by the Member pursuant to Section 4.6.

"Substitute Member" has the meaning set forth in Section 7.1.

"Transfer" means when used as a verb, to give, sell, exchange, assign, transfer, pledge, hypothecate, bequeath, devise or otherwise dispose of or encumber, and when used as a noun, the nouns corresponding to such verbs, in either case voluntarily or involuntarily, by operation of law or otherwise.

"UCC" means the Uniform Commercial Code as in effect in the State of Delaware from time to time.

1.2 **Other Definitional Provisions.**

(a) As used in this Agreement, accounting terms not defined in this Agreement, and accounting terms partly defined to the extent not defined, shall have the respective meanings given to them under generally accepted accounting principles.

(b) The words "hereof," "herein" and "hereunder" and words of similar import when used in this Agreement shall refer to this Agreement as a whole and not to any particular provision of this Agreement, and section, subsection, schedule and exhibit references are to this Agreement unless otherwise specified.

(c) Words of the masculine gender shall be deemed to include the feminine or neuter genders, and vice versa, where applicable. Words of the singular number shall be deemed to include the plural number, and vice versa, where applicable.

ARTICLE II - BUSINESS PURPOSES; OFFICES

2.1 **Name and Business Purpose.** The name of the Company shall be as stated in the Certificate. The business purpose of the Company is to own and operate a critical access hospital and related medical facilities located in Ripley, Tennessee, under the name of Lauderdale Community Hospital (the "Hospital") and to do any and all things necessary, appropriate or incidental thereto. The Company is formed only for such business purpose and shall not be deemed to create any declaration or agreement by the Company or the Member with respect to any other activities whatsoever other than the activities within such business purpose.

2.2 **Powers.** In addition to the powers and privileges conferred upon the Company by law and those incidental thereto, the Company shall have the same powers as a natural Person to do all things necessary or convenient to carry out its business and affairs.

2.3 **Principal Office.** The principal office of the Company shall be located at such places as the Member may determine from time to time.

2.4 **Registered Office and Registered Agent.** The location of the registered office and the name of the registered agent of the Company in the State of Delaware shall be as stated in the Certificate. The registered office and registered agent of the Company in the State of Delaware may be changed, from time to time, by the Member.

2.5 **Amendment of the Certificate.** The Company shall amend the Certificate at such time or times and in such manner as may be required by the Act and this Agreement.

2.6 **Effective Date.** This Agreement shall be effective on the date of this Agreement.

2.7 **Liability of Member.** No Member, solely by reason of being a Member, shall be liable, under a judgment, decree or order of a court, or in any other manner, for a debt, obligation or liability of the Company, whether arising in contract, tort or otherwise, or for the acts or omissions of any other Member of the Company. The failure of the Company to observe any formalities or requirements relating to the exercise of its powers or management of its business or affairs under this Agreement or the Act shall not be grounds for imposing liability on the Member for liabilities of the Company.

2.8 **Interest Not Acquired for Resale.** The Member is acquiring an Interest for the Member's own account as an investment and without an intent to distribute such Interest, which Interest has not been registered under the Securities Act of 1933, as amended, or any state securities laws, and the Member's Interest may not be resold or transferred without appropriate registration or the availability of an exemption from such requirements.

ARTICLE III - CAPITAL CONTRIBUTIONS; LOANS; UNITS OF INTERESTS

3.1 **Initial Capital Contributions.** The Member has heretofore contributed initial capital to the Company as set forth in Exhibit A.

3.2 **Additional Capital Contributions.** On the date hereof, the Member has contributed additional capital to the Company as set forth in Exhibit A. The Member shall not be obligated to make any other additional contributions to the capital of the Company and, accordingly, the Member shall not be liable for damage to the Company as a result of the failure of the Member to make any additional contributions. The Member may, however, make such additional contributions to the capital of the Company as determined from time to time by the Member.

3.3 **Capital Accounts.** A Capital Account shall be maintained by the Company for the Member and any Transferee. No interest will be paid on capital contributions.

3.4 **Capital Withdrawal Rights, Interest.** Except as expressly provided in this Agreement or as otherwise determined by the Member, (a) the Member shall not be entitled to withdraw or reduce the Member's Capital Account or to receive any Distributions, (b) the Member shall not be entitled to demand or receive any Distributions in any form other than in cash, and (c) the Member shall not be entitled to receive or be credited with any interest on any balance in the Member's Capital Account at any time.

3.5 **Loans.** The Member may make loans to the Company in such amounts, at such times, and on such terms and conditions as may be determined by the Member. Loans by the Member to the Company shall not be considered as contributions to the capital of the Company.

3.6 **Authorized Units.** The Company shall be authorized to issue not more than one hundred (100) units of Interests, each unit representing a one (1%) percent percentage Interest in the Company. The number of authorized units may be increased only with the written consent of the Member and the Lender. Each unit of Interest shall be represented by a certificate, in form set forth in Exhibit B, and shall constitute a security within the meaning of, and governed by, Article 8 of the UCC.

3.7 **Certificates.** Certificates representing units of Interests shall be issued in numerical order, and a Member shall be entitled to a certificate signed by, or in the name of the Company by, the President or a Vice President and by the Secretary or an Assistant Secretary, certifying the number of units of Interests owned by such Member. The signatures on such certificate may be a facsimile. In case any officer, transfer agent or registrar who has signed or whose facsimile signature has been placed upon a certificate shall have ceased to be such officer, transfer agent or registrar before such certificate is issued, such certificate may nevertheless be issued by the Company with the same effect as if such officer, transfer agent or registrar who signed such certificate, or whose facsimile signature shall have been used thereon, were such officer, transfer agent or registrar of the Company at the date of issue.

3.8 **Transfers of Interests.** Transfers of units of Interests shall be made only upon the books of the Company, kept at the office of the Company or of the transfer agent designated to transfer the Interests or Units, and before a new certificate is issued the old certificate shall be surrendered for cancellation, subject to the provisions of Section 3.10 of this Agreement. Until and unless the Company appoints some other person, firm or corporation as its transfer agent (and upon the revocation of any such appointment, thereafter until a new appointment is similarly made), the Secretary or Assistant Secretary of the Company shall be the transfer agent of the Company without the necessity of any formal action of the Member or Managing Directors, and the Secretary or Assistant Secretary, or any other person designated by the Secretary, shall perform all of the duties of such transfer agent.

3.9 **Registered Members.** Only Members whose names are registered in the books of the Company shall be entitled to be treated by the Company as the holders and owners in fact of the units of Interests standing in their respective names, and the Company shall not be bound to recognize any equitable or other claim to or interest in such units of Interest on the part of any other person, whether or not it shall have express or other notice thereof, except as expressly provided by the Act.

3.10 **Lost Certificates.** The Managing Directors may direct that a new certificate or certificates be issued in place of any certificate or certificates theretofore issued by the Company, alleged to have been lost, stolen or destroyed, upon the making of an affidavit of that fact by the person claiming the certificate or certificates to be lost, stolen or destroyed. When authorizing the issue of such replacement certificate or certificates, the Managing Directors may, in their discretion and as a condition precedent to the issuance thereof, require the owner of such allegedly lost, stolen or destroyed certificate or certificates, or such owner's legal representative, to give the Company a bond in such sum as it may direct to indemnify the Company against any claim that may be made against it on account of the alleged loss, theft or destruction of any such certificate or the issuance of such new certificate or certificates.

ARTICLE IV - ALLOCATIONS AND DISTRIBUTIONS

4.1 **Non-Liquidation Cash Distributions.** The amount, if any, of Available Cash may be determined and distributed by the Member at any time and from time to time.

4.2 **Liquidation Distributions.** Liquidation Proceeds shall be distributed in the following order of priority:

(a) To the payment of debts and liabilities of the Company (including to the Member to the extent otherwise permitted by law and applicable contractual restrictions) and the expenses of liquidation;

(b) Next, to the setting up of such reserves as the Person required or authorized by law to wind up the Company's affairs may reasonably deem necessary or appropriate for any disputed, contingent or unforeseen liabilities or obligations of the Company, provided that any such reserves shall be paid over by such Person to an independent escrow agent, to be held by such agent or its successor for such period as such Person shall deem advisable for the purpose of applying such reserves to the payment of such liabilities or obligations and, at the expiration of such period, the balance of such reserves, if any, shall be distributed as hereinafter provided and

(c) The remainder to the Member.

4.3 **Income, Losses and Credits.** The Company's Income or Loss, as the case may be, and applicable Credits, for each fiscal year of the Company, as determined in accordance with such method of accounting as may be adopted for the Company, shall be allocated to the Member for both financial accounting and income tax purposes, except as otherwise provided for herein or unless the Member determines otherwise.

4.4 **Withholding of Distributions.** Notwithstanding any other provision of this Agreement, the Member (or any Person required or authorized by law to wind up the Company's affairs) may suspend, reduce or otherwise restrict Distributions when, in the Member's sole opinion, such action is in the best interests of the Company.

4.5 **Tax Withholding.** Notwithstanding any other provision of this Agreement, the Member may take any action that the Member determines is necessary or appropriate to cause the Company to comply with any withholding requirements established under any federal, state or local tax law, including, without limitation, withholding on any Distributions to the Member. For all purposes of this Article IV, any amount withheld on any Distributions and paid over to the appropriate governmental body may be treated as if such amount had in fact been distributed to the Member.

4.6 **Reserves.** The Member shall have the right to establish, maintain and expend Reserves to provide for working capital, for future maintenance, repair or replacement of the Property, for debt service, for future investments and for such other purposes as the Member may deem necessary or advisable.

ARTICLE V - MANAGEMENT

5.1 **Management by Managing Directors.**

(a) **General.** Subject to all other provisions of this Agreement, the business and affairs of the Company shall be managed by at least two (2) individuals (each a "Managing Director." The Managing Directors shall be designated by the affirmative vote or written consent of Members holding a Majority Interest. Except as expressly limited by law, the Certificate or this Agreement, the Property and the business of the Company shall be controlled and managed by

the Managing Directors. The Managing Directors shall have and are vested with all powers and authorities, except as expressly limited by law, the Certificate, or this Agreement, to do or cause to be done any and all lawful things for and in behalf of the Company, to exercise or cause to be exercised any or all of its powers, privileges and franchises, and to seek the effectuation of its objects and purposes. In limitation of the powers conferred by this Agreement or by statute, the Managing Directors are expressly prohibited from making, repealing, altering, amending or rescinding any or all of this Agreement, the Certificate, and the Bylaws of the Company.

(b) **Delegation of Authority to Adopt Bylaws.** At any time and from time to time, the Managing Directors may in its discretion adopt bylaws and rules and procedures ("collectively, the "Bylaws") that are consistent with this Agreement, for the purpose of enabling the Managing Directors to carry out its responsibilities. Bylaws shall be subject to the approval of the Member, and the Member retains the right to rescind any authority or procedures delegated to the Managing Directors.

(c) **Delegation of Authority and Appointment of Officers.** At any time and from time to time, the Managing Directors may in its discretion designate any Person to carry out the decisions of the Managing Directors or the Member, including, but not limited to, the execution of any instruments on behalf of the Company. The Managing Directors shall have the power and authority to appoint individuals to act as officers of the Company or to act in such other capacities or on such committees as the Managing Directors deem advisable from time to time, and any such individuals shall serve for such periods and hold such positions, have such power and authority and be subject to such restrictions or limitations, and be entitled to such compensation, as the Managing Directors may determine from time to time. Any number of titles may be held by the same individual. Any appointment or delegation of authority may be revoked, and any individual may be removed from any officer position or other capacity, at any time by the Managing Directors, with or without cause.

(d) **Advisory Directors.** The Bylaws may authorize and establish procedures for the appointment of advisory directors for the purpose of providing advice and assistance to the Managing Directors in regard to the business and affairs of the Company, provided such advisory directors shall not have any authority to bind, or otherwise take any actions on behalf of, the Managing Directors or the Company.

(e) **Restrictions on Authority.** Neither the Managing Directors, nor any officer, or other representative of the Company, shall be authorized to act in connection with the following matters, except with the affirmative vote or written consent of Members holding a Majority Interest.

(i) Make any loan to any Member;

(ii) Enter into or amend any transaction between the Company and an affiliate of the Member, or establish or pay any salaries, bonuses, or other forms of compensation to Persons who are employees or affiliates of the Member for services as employees, consultants, agents or representatives of the Company;

(iii) Assume, incur or guaranty or become liable for any indebtedness for borrowed money on behalf of the Company;

(iv) Sell, exchange, lease, mortgage, pledge or otherwise dispose of all or substantially all of the assets of the Company in a single transaction or series of related transactions;

(v) Merge or consolidate the Company with or into another entity;

(vi) Terminate, dissolve or windup the Company;

(vii) Commingle the Company's funds with those of any other Person;

(viii) Change the status of the Company from one in which management is vested in the Managing Directors to one in which management is vested in the Member or a manager;

(ix) No Managing Director or officer of the Company shall enter into any transaction or agreement on behalf of the Company, nor otherwise take any action on behalf of the Company, unless such transaction, agreement or action is permitted or authorized in accordance with the terms of this Agreement.

5.2 **Actions by Member.** Any consent, approval, decision or other action required or permitted to be taken by the Member, as contemplated in this Agreement or required by the Act or other applicable law, may be taken without a meeting, without prior notice and without a vote, if one or more written consents setting forth the consent, approval, decision or other action to be taken shall be signed by the Member. The Member shall communicate its actions through its Authorized Representative who has been appointed by the Member pursuant to the Management Agreement between the Company and Rural Community Hospitals of America, LLC, dated January 17, 2013.

5.3 **Execution of Documents Filed with Secretary of State of Delaware.** Any Director or other Persons designated from time to time by the Managing Directors shall be authorized to execute and file with the Secretary of State of Delaware any document permitted or required by the Act. Such documents shall be executed and filed only after the Managing Directors, or the Member to the extent applicable, have approved or consented to such action in the manner provided herein. The Member hereby waives any requirement under the Act of receiving a copy of any document filed with the Secretary of State of Delaware.

5.4 **Indemnification.** The following indemnification provisions shall apply to the Persons enumerated below.

(a) **Right to Indemnification of Managing Directors and Officers.** The Company shall indemnify and hold harmless, to the fullest extent permitted by applicable law as it presently exists or may hereafter be amended, any Person (an "Indemnified Person") who was or is made or is threatened to be made a party or is otherwise involved in any action, suit or proceeding, whether civil, criminal, administrative or investigative (a "Proceeding"), by reason of the fact that such Person, or a Person for whom such Person is the legal representative, is or was a Director or officer of the Company or, while a Director or officer of the Company, is or was serving at the request of the Company as a Director, officer, employee or agent of another Company or of a partnership, joint venture, limited liability company, trust, enterprise or nonprofit entity, including service with respect to employee benefit plans, against all liability and loss suffered and expenses (including attorneys' fees) reasonably incurred by such Indemnified Person in such Proceeding. Notwithstanding the preceding sentence, except as otherwise provided in subsection (c) of this Section 5.4, the Company shall be required to indemnify an Indemnified Person in connection with a Proceeding (or part thereof) commenced by such Indemnified Person only if the commencement of such Proceeding (or part thereof) by the Indemnified Person was authorized in advance by the Managing Directors.

(b) **Prepayment of Expenses of Managing Directors and Officers.** The Company shall pay the expenses (including attorneys' fees) incurred by an Indemnified Person in

defending any Proceeding in advance of its final disposition, provided, however, that, to the extent required by law, such payment of expenses in advance of the final disposition of the Proceeding shall be made only upon receipt of an undertaking by the Indemnified Person to repay all amounts advanced if it should be ultimately determined that the Indemnified Person is not entitled to be indemnified under this Section 5.4 or otherwise.

(c) **Claims by Managing Directors and Officers.** If a claim for indemnification or advancement of expenses under this Section 5.4 is not paid in full within 30 days after a written claim therefor by the Indemnified Person has been received by the Company, the Indemnified Person may file suit to recover the unpaid amount of such claim and, if successful in whole or in part, shall be entitled to be paid the expense of prosecuting such claim. In any such action the Company shall have the burden of proving that the Indemnified Person is not entitled to the requested indemnification or advancement of expenses under applicable law.

(d) **Indemnification of Employees and Agents.** The Company may indemnify and advance expenses to any Person who was or is made or is threatened to be made or is otherwise involved in any Proceeding by reason of the fact that such Person, or a Person for whom such Person is the legal representative, is or was an employee or agent of the Company or, while an employee or agent of the Company, is or was serving at the request of the Company as a Director, officer, employee or agent of another limited liability company or of a partnership, joint venture, corporation, trust, enterprise or nonprofit entity, including service with respect to employee benefit plans, against all liability and loss suffered and expenses (including attorney's fees) reasonably incurred by such Person in connection with such Proceeding. The ultimate determination of entitlement to indemnification of Persons who are non-Director or officer employees or agents shall be made in such manner as is determined by the Managing Directors in its sole discretion. Notwithstanding the foregoing sentence, the Company shall not be required to indemnify a Person in connection with a Proceeding initiated by such Person if the Proceeding was not authorized in advance by the Managing Directors.

(e) **Advancement of Expenses of Employees and Agents.** The Company may pay the expenses (including attorney's fees) incurred by an employee or agent in defending any Proceeding in advance of its final disposition on such terms and conditions as may be determined by the Managing Directors.

(f) **Non-Exclusivity of Rights.** The rights conferred on any Person by this Section 5.4 shall not be exclusive of any other rights which such Person may have or hereafter acquire under any statute, provision of the Certificate, this Agreement, consent of the Member or disinterested Directors or otherwise.

(g) **Other Indemnification.** The Company's obligation, if any, to indemnify any Person who was or is serving at its request as a Director, officer or employee of another limited liability company, partnership, corporation, joint venture, trust, organization or other enterprise shall be reduced by any amount such Person may collect as indemnification from such other limited liability company, partnership, corporation, joint venture, trust, organization or other enterprise.

(h) **Insurance.** The Managing Directors may, to the full extent permitted by applicable law as it presently exists, or may hereafter be amended from time to time, authorize an appropriate officer or officers to purchase and maintain at the Company's expense insurance: (a) to indemnify the Company for any obligation which it incurs as a result of the indemnification of Directors, officers and employees under the provisions of this Section 5.4; and (b) to indemnify or insure Directors, officers and employees against liability in instances in which they may not otherwise be indemnified by the Company under the provisions of this Section 5.4.

(i) **Amendment or Repeal.** Any repeal or modification of the foregoing provisions of this Section 5.4 shall not adversely affect any right or protection hereunder of any Person in respect of any act or omission occurring prior to the time of such repeal or modification. The rights provided hereunder shall inure to the benefit of any Indemnified Person and such Person's heirs, executors and administrators.

ARTICLE VI - ACCOUNTING AND BANK ACCOUNTS

6.1 **Fiscal Year.** The fiscal year and taxable year of the Company shall end on September 30th of each year, unless a different year is required by the Code or otherwise established by the Member.

6.2 **Books and Records.** At all times during the existence of the Company, the Company shall cause to be maintained full and accurate books of account, which shall reflect all Company transactions and be appropriate and adequate for the Company's business. The books and records of the Company shall be maintained at the principal office of the Company. The Member (or the Member's designated representative) shall have the right during ordinary business hours and upon reasonable notice to inspect and copy (at the Member's own expense) all books and records of the Company.

6.3 **Bank Accounts.** All funds of the Company shall be deposited in a separate bank, money market or similar account(s) approved by the Member and in the Company's name. Withdrawals therefrom shall be made only by Persons authorized to do so by the Member.

ARTICLE VII - TRANSFERS OR ENCUMBRANCE OF INTERESTS

7.1 **Transfer and Assignment of Interests.** No Member shall be entitled to Transfer all or any part of his or her Interest in the Company except with the prior written consent of all of the other Members, which consent may be given or withheld, conditioned or delayed (as allowed by this Agreement or the Act), as the other Members may determine in their sole discretion. Transfers in violation of this Article VII shall only be effective to the extent set forth in Section 7.6. After the consummation of any Transfer of any part of an Interest, the Interest so Transferred shall continue to be subject to the terms and provisions of this Agreement and any further Transfers shall be required to comply with all the terms and provisions of this Agreement.

7.2 **Substitution of Members.** A transferee of an Interest shall have the right to become a substitute Member only if (a) the requirements of Section 7.1 are met, (b) such transferee executes an instrument satisfactory to the Managing Directors accepting and adopting the terms and provisions of this Agreement, and (c) such transferee pays any reasonable expenses in connection with his or her admission as a substitute Member. The admission of a substitute Member shall not result in the release of the Member who assigned the Membership Interest from any liability that such Member may have to the Company.

7.3 **Family and Affiliate Transfers.** The Interest of any Member may be transferred subject to compliance with Section 7.2 and without the prior written consent of all Members as required by Section 7.1, upon consent of the Managing Directors, which shall not be unreasonably withheld, by the Member (a) by *inter vivos* gift or by testamentary transfer to any spouse, parent, sibling, in-law, child or grandchild of the Member, or to a trust for the benefit of the Member or such spouse, parent, sibling, in-law, child or grandchild of the Member, or (b) to

any affiliate of the Member; it being agreed that in executing this Agreement, each Member has consented to such transfers.

7.4 **Effective Date of Permitted Transfers.** Any permitted transfer of all or any portion of an Interest shall be effective as of the first business day following the date upon which the requirements of Sections 7.1, 7.2 and 7.3 have been met. The Managing Directors shall provide the Members with written notice of such transfer as promptly as possible after the requirements of Sections 7.1, 7.2 and 7.3 have been met. Any transferee of an Interest shall take subject to the restrictions on transfer imposed by this Agreement.

7.5 **Rights of Legal Representatives.** If a Member who is an individual dies or is adjudged by a court of competent jurisdiction to be incompetent to manage the Member's person or property, the Member's executor, administrator, guardian, conservator, or other legal representative may exercise all of the Member's rights for the purpose of settling the Member's estate or administering the Member's property, including any power the Member has under the Certificate or this Agreement to give an assignee the right to become a Member. If a Member is a corporation, trust, or other entity and is dissolved or terminated, the powers of that Member may be exercised by his or her legal representative or successor.

7.6 **No Effect to Transfers in Violation of Agreement.** Upon any transfer of a Membership Interest in violation of this Article VII, the transferee shall have no right to vote or participate in the management of the business, property and affairs of the Company or to exercise any rights of a Member. Such transferee shall only be entitled to become the owner of an Economic Interest Owner and thereafter shall only receive the share of one or more of the Company's net profits, net losses and Distributions to which the transferor of such Economic Interest would otherwise be entitled. Notwithstanding the immediately preceding sentences, if, in the determination of the Managing Directors, a transfer in violation of this Article VII would cause the termination of the Company under the Act, in the sole discretion of the Managing Directors, the transfer shall be null and void and the purported transferee shall not become either a Member or the owner of an Economic Interest Owner.

7.7 **Pledge of Interests.** Notwithstanding any provision of this Agreement to the contrary, the Member may pledge and otherwise encumber its Interests for the purpose of securing the loan between the Lender and the Member.

ARTICLE VIII - DISSOLUTION AND TERMINATION

8.1 **Events Causing Dissolution.** The Company shall be dissolved only upon the first to occur of the following events:

(a) The expiration of the term of the Company, as set forth in Section 2.6.

(b) Upon the entry of a decree of judicial dissolution under Section 18-802 of the Act.

8.2 **Effect of Dissolution.** Except as otherwise provided in this Agreement, upon the dissolution of the Company, the Member shall take such actions as may be required pursuant to the Act and shall proceed to wind up, liquidate and terminate the business and affairs of the Company. In connection with such winding up, the Member shall have the authority to liquidate and reduce to cash (to the extent necessary or appropriate) the assets of

the Company as promptly as is consistent with obtaining Fair Value therefor, to apply and distribute the proceeds of such liquidation and any remaining assets in accordance with the provisions of Section 8.3, and to do any and all acts and things authorized by, and in accordance with, the Act and other applicable laws for the purpose of winding up and liquidation.

8.3 **Application of Proceeds.** Upon dissolution and liquidation of the Company, the assets of the Company shall be applied and distributed in the order of priority set forth in Section 4.2.

ARTICLE IX - MISCELLANEOUS

9.1 **Title to the Property.** Title to the Property shall be held in the name of the Company. The Member shall not individually have any ownership interest or rights in the Property, except indirectly by virtue of the Member's ownership of an Interest.

9.2 **Nature of Interest in the Company.** An Interest shall be Personal property for all purposes.

9.3 **Notices and Determinations.** Any notice or determination required or permitted to be given or made by this Agreement or the Act shall be sufficient if given or made in writing.

9.4 **No Third Party Rights.** None of the provisions contained in this Agreement shall be for the benefit of or enforceable by any third parties, including, but not limited to, creditors of the Company; provided, however, the Company may enforce any rights granted to the Company under the Act, the Certificate, or this Agreement.

9.5 **Amendments to this Agreement.** This Agreement shall not be modified or amended in any manner other than by the Member.

9.6 **Severability.** If any provision of this Agreement is held to be illegal, invalid or unenforceable to any extent, the legality, validity and enforceability of the remainder of this Agreement shall not be affected thereby and shall remain in full force and effect and shall be enforced to the greatest extent permitted by law.

9.7 **Binding Agreement.** The provisions of this Agreement are binding upon, and will inure to the benefit of, the parties hereto and their respective heirs, Personal representatives, successors and permitted assigns.

9.8 **Headings.** The headings of the Certificate and the sections of this Agreement are for convenience only and shall not be considered in construing or interpreting any of the terms or provisions thereof and hereof.

9.9 **Governing Law.** This Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware.

EXHIBIT A

Initial Capital Contribution	Percentage Interest
$875,000.00	**100%**

Additional Capital Contribution

$1,250,000

EXHIBIT B

LIMITED LIABILITY COMPANY CERTIFICATE

Certificate Number ___ ___% of Interests/# of Units

CAH ACQUISITION COMPANY 11, LLC, a Delaware limited liability company ("Company"), hereby certifies that _____ ("Holder") is the registered owner under this Certificate of ___% of the Interests in the Company or ___ Units in the Company.

By acceptance of this Certificate and as a condition to being entitled to any rights and/or benefits with respect to the Interests and Units evidenced hereby, the Holder is deemed to have agreed to comply with and be bound by all the terms and conditions of the Company's Operating Agreement. The Company will furnish a copy of the Operating Agreement to the Holder without charge upon written request to the Company at its principal place of business.

Each Interest and Unit in the Company shall constitute a Security within the meaning of, and governed by, Article 8 of the Delaware Uniform Commercial Code, including § 8-102(a)(15) thereof. This Certificate shall constitute a Certificated Security within the meaning of, and governed by Article 8 of the Delaware Uniform Commercial Code, including § 8-102(a)(4) thereof.

This Certificate shall be governed by and construed in accordance with the laws of the State of Delaware without regard to principles of conflicts of laws.

THE RIGHTS, POWERS, PREFERENCES, RESTRICTIONS (INCLUDING TRANSFER RESTRICTIONS) AND LIMITATIONS OF THE INTERESTS ARE SET FORTH IN, AND THIS CERTIFICATE AND THE INTERESTS AND UNITS REPRESENTED HEREBY ARE ISSUED AND SHALL IN ALL RESPECTS BE SUBJECT TO THE TERMS AND PROVISIONS OF, THE FIRST AMENDED AND RESTATED LIMITED LIABILITY COMPANY AGREEMENT ("OPERATING AGREEMENT") OF THE COMPANY, DATED _____, 2013, AS THE SAME MAY BE AMENDED OR RESTATED FROM TIME TO TIME. THE TRANSFER OF THIS CERTIFICATE AND THE INTERESTS AND UNITS REPRESENTED HEREBY IS RESTRICTED AS DESCRIBED IN THE OPERATING AGREEMENT.

IN WITNESS WHEREOF, the Company has caused this Certificate to be executed by Gordon Lansford, in his capacity as the Vice President of the Company, as of the date set forth below.

CAH ACQUISITION COMPANY 11, LLC

By: _____
Vice President

Date: _____

(REVERSE SIDE OF CERTIFICATE)

FOR INTERESTS AND UNITS OF CAH ACQUISITION COMPANY 11, LLC, for value received, the undersigned hereby sells, assigns and transfers unto _____ *(print or typewrite name of transferee)*, _____ *(insert taxpayer identification number of transferee)*, the following specified percentage of Interests and Units: _____ *(identify the percentage of Interests and number of units being transferred)*, and irrevocably constitutes and appoints _____, as its attorney-in-fact, to transfer the same on the books and records of the Company, with full power of substitution in the premises.

Dated: _____

HMC/CAH CONSOLIDATED, INC.

By: _____
_____Vice President

Attest: _____
_____ Assistant Secretary

Date: _____

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

LINDA WAY
LINDA WAY
1100 MAIN STREET, SUITE 2350
KANSAS CITY, MO 64105

January 6, 2016

Request Type: Certificate of Existence/Authorization
Request #: 0189752

Issuance Date: 01/06/2016
Copies Requested: 1

Document Receipt

Receipt # : 002373872 Filing Fee: $20.00

Payment-Credit Card - State Payment Center - CC #: 3660708584 $20.00

Regarding: CAH Acquisition Company 11, LLC
Filing Type: Limited Liability Company - Foreign
Formation/Qualification Date: 10/20/2009
Status: Active
Duration Term: Perpetual

Control # : 615727
Date Formed: 07/07/2008
Formation Locale: DELAWARE
Inactive Date:

CERTIFICATE OF AUTHORIZATION

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

CAH Acquisition Company 11, LLC

* is a Limited Liability Company formed in the jurisdiction set forth above and is authorized to transact business in this State;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed an Application for Certificate of Withdrawal.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 015541216

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 2

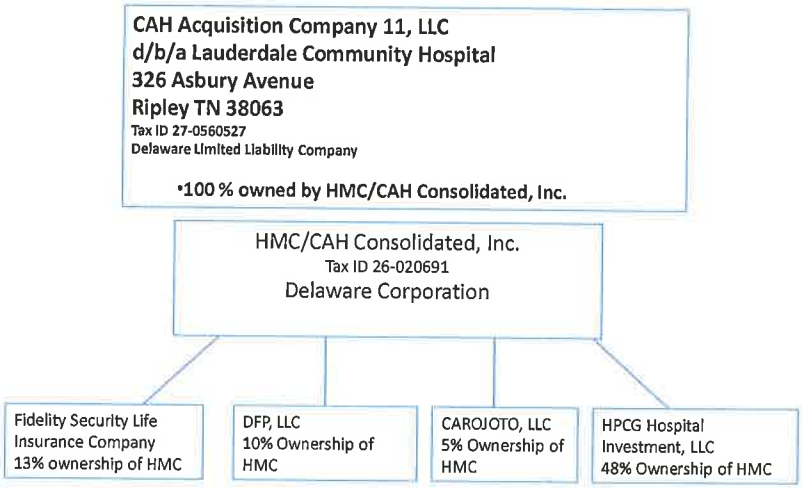
Section A, Item 4

Ownership Structure

Attachment 2
Section A, Item 4
Ownership Structure

CAH Acquisition Company 11, LLC ("CAH 11")
d/b/a Lauderdale Community Hospital

100 % owned by HMC/CAH Consolidated, Inc. ("HMC") –



HMC and CAH 11 do not have a financial interest in any other health care institution in Tennessee.

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 3

Section A, Item 5

Management Agreement

MANAGEMENT AGREEMENT

(Lauderdale Community Hospital, Ripley, TN)

This MANAGEMENT AGREEMENT ("Agreement") is by and among HMC/CAH CONSOLIDATED, INC., a Delaware corporation ("HMC"), and CAH Acquisition Company 11, LLC, a Delaware limited liability company ("CAH11"), and RURAL COMMUNITY HOSPITALS OF AMERICA, LLC, a West Virginia limited liability company ("Manager"). HMC and CAH11 are referred to individually as "HMC Party" and collectively as "HMC Parties". HMC Parties and Manager are referred to individually as a "Party" and collectively as the "Parties."

PREMISES

A. HMC owns through a consolidated group of wholly-owned subsidiaries twelve (12) acute care hospitals and associated clinics located in rural communities, all of which are certified by CMS as Critical Access Hospitals and some of the clinics are certified by CMS as Rural Health Clinics.

B. CAH11 is a subsidiary of HMC and the owner of Lauderdale Community Hospital, 328 Asbury Drive, Ripley, TN 38063 and its associated clinics located (collectively, the "Hospital").

C. HMC is currently operating and managing the hospitals and clinics owned by its subsidiaries as an operationally unified and financial integrated healthcare system (the "Hospital System").

D. HMC and CAH11 have decided to discontinue management of the Hospital and to contract with Manager to manage the day-to-day operations of the Hospital and certain operations of HMC. HMC and its other subsidiaries have made the same decision for the other hospitals and clinics. In making their decision, HMC Parties acknowledge that Manger intends to provide management and consulting services, or to own and operate other hospitals that are not a part of the Hospital System.

AGREEMENT

NOW, THEREFORE, for and in consideration of the mutual covenants and conditions contained herein and other good and valuable consideration, the receipt and adequacy of which are hereby forever confessed, the Parties agree as follows:

SECTION 1

TERMS GENERALLY; DEFINITIONS

1.01 Terms Generally. As used in this Agreement, (a) the word "or" is not exclusive, (b) the words "consent" and "approval" are synonymous and, except as otherwise specified herein, are deemed to be followed by the phrase "which shall not be unreasonably withheld or delayed," (c) the words "include," "includes" and "including" shall be deemed to be followed by the phrase "without limitation," (d) any pronoun shall include the corresponding masculine, feminine and neuter forms, (e) words in the singular number include words in the plural and vice versa unless the context of the usage of such term clearly indicates otherwise, (f) accounting terms that are used, but not otherwise defined herein, are to be construed and interpreted in accordance with "generally accepted accounting principles" and procedures

(GAAP) in effect on the Commencement Date, and (g) the phrase "made available to a Party" shall mean made available to such Party via email, facsimile or other electronic transfer or through other written means for purposes of this Agreement.

1.02 Jointly Drafted. The Parties have been advised by experienced counsel, and have participated jointly in the negotiation and drafting of this Agreement and, in the event an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as jointly drafted in its entirety by the Parties and no presumption or burden of proof shall arise favoring or disfavoring any Party by virtue of the authorship of any provision of this Agreement.

1.03 Definitions. For purposes of this Agreement, the following words and phrases shall have the following respective interpretations and meanings:

(a) "Additional Payments" means payments made by HMC Parties to Manager for Additional Services. The Parties acknowledge and agree that the Additional Payments shall be (i) negotiated in good faith by the Parties based upon market rates for activities of similar scope and complexity in the marketplace and (ii) contingent upon the successfully originating and closing the transaction upon which the Additional Payments are based.

(b) "Additional Services" means (i) any services performed by Manager in connection with a Capital Project or (ii) any other *ad hoc* advisory or consulting services or activities that are not included in, or related to, the Services. By way of illustration and not limitation, Additional Services would include activities related to equity or debt financings and/or re-financings for the Hospital whether in connection with a Capital Project or otherwise, or the sale of the Hospital or purchase of an additional hospital facility from a third-party. Additional Services would not include the start up work related to the opening of a new clinic or other line of clinical services for the Hospital or the performance of any other operational services (whether or not such services are included in the Services) that are currently performed by an HMC Party's in-house personnel to the Hospital.

(c) "Affiliate" means any corporation, partnership, joint venture or other entity controlled by, controlling or under common control with, directly or indirectly, any of the Parties or any one of such entities.

(d) "Applicable Laws" means any federal, State, or local statute, law, municipal charter provision, regulation, ordinance, rule, mandate, judgment, order, decree, permit, code or license requirement or other governmental requirement or restriction, including Conditions of Participation, or any interpretation or administration of any of the foregoing by any governmental authority, which applies to the obligations of any Party under this Agreement, whether now or hereafter in effect.

(e) "Approved Budget" shall have the meaning set forth in Section 4.03(b).

(f) "Authorized Representative" means the natural persons and any successors designated by Manager and HMC Parties pursuant to Section 11.05 to represent such Parties, and to act on the behalf of such Parties, under this Agreement. Any and all references to the taking of any action, or the giving of any consent, by a Party under this Agreement shall be deemed to include the taking of such action, or the giving of such consent, by the Party's Authorized Representative

(g) "Billing Month" means each accounting month of Manager. For each quarter of the Billing Year, there will be a 4/4/5 week cycle of three (3) consecutive Billing Months. The first Billing Month shall begin on the Commencement Date. The first Billing Month of each Billing Year shall begin on October 1st and the last Billing Month of each Billing Year shall end on September 30th, except that the last Billing Month shall end concurrently with the expiration of this Agreement or, as applicable, the date of termination of this Agreement.

(h) ""Billing Year" means a Fiscal Year comprising twelve (12) Billing Months, except that (i) the first Billing Year shall commence on the Commencement Date and end on September 30th immediately following the Commencement Date and (ii) the last Billing Year shall end concurrently with the end of the term or, as applicable, the date of termination, of this Agreement.

(i) "Board" means, as applicable, the Board of Directors of HMC or the Board of Managers of CAH11.

(j) "Capital Project" means (i) a project for the modification, alteration, addition to, and or improvement to the existing facilities or equipment of the Hospital having a project cost in excess of $1,000,000, or (ii) a project for the replacement (including the acquisition of the replacement site) of the existing Hospital facilities with new facilities. For the avoidance of doubt, the Parties acknowledge and agree that (x) installation of electronic medical records (EMR) by the Hospital System and (y) the replacement of the existing CPSI financial system for the Hospital System by NexGen Software Group are not Capital Projects.

(k) "Cash" means currency and coins on hand, bank balances, and negotiable money orders and checks.

(l) "Change in Control" shall mean:

(1) The acquisition by any Person of beneficial ownership or more of the combined voting power of the then outstanding voting securities of a Person entitled to vote generally in the election of directors or managers ("Outstanding Voting Securities"); or

(2) The approval by the shareholders or members of a Person of a reorganization, merger or consolidation, unless following such reorganization, merger or consolidation:

(i) more than 51% of the combined voting power of the then outstanding voting securities of such reorganized, merged or consolidated Person entitled to vote generally in the election of directors or managers is then beneficially owned directly or indirectly, by all or substantially all of the same Persons who were the beneficial owners of the Outstanding Voting Securities immediately prior to such reorganization, merger or consolidation in substantially the same proportions as their ownership, immediately prior to such reorganization, merger or consolidation, of the Outstanding Voting Securities; and

(ii) at least a majority of the members of the board of directors or managers of the Person resulting from such reorganization, merger or consolidation were members of the incumbent board of directors or managers at the time of the

execution of the initial agreement providing for such reorganization, merger or consolidation; or

(3) The approval by the shareholders or members of a Person of a complete liquidation or dissolution of the Person, or the sale or other disposition of all or substantially all of the assets of the Person, other than to a Person with respect to which following such sale or other disposition:

(i) more than 51% of the combined voting power of the then outstanding voting securities of such Person entitled to vote generally in the election of directors or managers is then beneficially owned, directly or indirectly, by all or substantially all of the same Persons who were the beneficial owners of the Outstanding Voting Securities immediately prior to such sale or other disposition in substantially the same proportion as their ownership immediately prior to such sale or other disposition, of the Outstanding Voting Securities; and

(ii) at least a majority of the members of the board of directors or manager of such Person were members of the incumbent board of directors or managers at the time of the execution of the initial agreement or action of the board providing for such sale or other disposition of assets.

(a) "Change in Law" means the enactment, adoption, promulgation, modification, repeal or change after the Commencement Date of any Applicable Law that (i) necessitates or makes advisable a Capital Project, (ii) increases the Service Fee by establishing requirements with respect to the operation or maintenance of the Hospital, or (iii) otherwise impacts a Party's ability to perform its obligations under this Agreement. For purposes of this definition, no enactment, adoption, promulgation or modification of an Applicable Law shall be considered a Change in Law if, as of the Commencement Date, such Applicable Law would have directly affected the continued operation, maintenance, repair or management of the Hospital by HMC Parties after the Commencement Date in the absence of this Agreement and either (i) such Applicable Law was officially proposed by the responsible agency and thereafter had become effective without further action, or (ii) the adoption, enactment or promulgation process by the appropriate federal, State or local body commenced before the Commencement Date, and with respect to which, (1) the comment period expired on or before the Commencement Date, (2) any required hearings concluded on or before the Commencement Date in accordance with applicable administrative procedures, and (3) it thereafter became effective without further action. The definition of "Change in Law" shall include changes in reimbursement rules and regulations or Conditions of Participation applicable to the Hospital under the Critical Access Hospital program.

(b) "CMS" means The Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services (DHHS).

(c) "Conditions of Participation" means the conditions that a hospital must meet to be designated as a Critical Access Hospital, as set forth in 42 C.F.R. Subpart F, Title 42: Public Health, Part 485—Conditions of Participation: Critical Access Hospitals.

(d) "Commencement Date" means the date this Agreement is executed, the commencement of the provision of Services by Manager hereunder, and the date upon which

the Term begins; provided, however, there shall be no Commencement Date unless and until all of the conditions set forth in Section 2 are satisfied or waived.

(e) "CPI" means the United States Department of Labor's Bureau of Statistics' Consumer Price Index, All Items index TABLE 1, for all urban consumers; U.S. City average for the applicable 12-month period. The current internet address for the CPI is ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt.

(f) "Documents" means all files, documents, instruments, papers, books, reports, records, tapes, microfilms, photographs, letters, budgets, forecasts, ledgers, journals, title policies, customer lists, regulatory filings, operating data and plans, technical documentation (design specifications, functional requirements, operating instructions, logic manuals, flow charts, etc.), user documentation (installation guides, user manuals, training materials, release notes, working papers, etc.), marketing documentation (sales brochures, flyers, pamphlets, web pages, etc.), and other similar materials related to the Hospital or the Hospital System in each case whether or not in electronic form.

(g) "Final Confirmation Order" means the Order entered by the United States Bankruptcy Court for the Western District of Missouri on December 12, 2012 confirming HMC Parties' Plan of Reorganization, which, pursuant the Federal Rules of Bankruptcy Procedure (Fed. R. Bankr. P. 8002(a)) became final fourteen (14) days later for purposes of appeal on December 26, 2012.

(h) "Fiscal Year" means the twelve (12) months beginning on October 1st of each year and ending on September 30th of each year.

(i) "Force Majeure" means any act, event or condition that has a direct material adverse effect on the performance of Manager's obligations, or on the performance of a subcontractor or supplier of its obligations to Manager, if such act, event or condition is beyond the reasonable control of Manager, subcontractor or supplier asserting a Force Majeure as justification for not performing its obligations; provided such act, event or condition cannot be caused by the negligent or intentional action of Manager, or subcontractor or supplier.

(j) "Hospital Expense" means:

(1) Any costs and expenses of operation and maintenance of the Hospital, including heat, water, electricity and all other utilities, insurance premiums, licenses, supplies, permits and inspection fees, costs of labor, services and materials incurred under contracts for the Hospital, and services provided by third-parties for legal services, accounting and audit services, and architectural services, feasibility studies, certificate of need applications and similar items related to a Capital Project; and

(2) Any other liabilities and obligations incurred in connection with the Hospital including all payment obligations and other obligations and liabilities arising under contracts for the Hospital with materialmen, mechanics or other parties whose charges can become liens against the Hospital's assets and facilities.

It is acknowledged and agreed by the Parties that Hospital Expenses shall not include those costs and expenses and liabilities and obligations that are incurred and paid by Manager in the performance of Services under the terms of this Agreement.

(k) "Hospital Personnel" means those employees of HMC Parties who are charged with carrying out the day-to-day work and duties of the Hospital, including physicians, nurses and other healthcare professionals, managerial and administrative personnel, housekeeping and janitorial workers.

(l) "Incentive Fee" has the meaning ascribed in Section 5.03.

(m) "Insolvency" means the occurrence of any of the following:

(1) Inability, failure, or refusal to pay debts as they mature, entry into an arrangement by any Party with or for the benefit of their creditors, or any Party's consent to or acquiescence in the appointment of a receiver, trustee, or liquidator for a substantial part of such Party's property; or

(2) A bankruptcy, winding up, reorganization, insolvency, arrangement, or similar proceeding instituted by or against any Party under the laws of any jurisdiction, which proceeding is not dismissed within sixty (60) days; or

(3) Any action or answer in a bankruptcy, winding up, reorganization, insolvency, arrangement, or similar proceeding in which any Party approves of, consents to, or acquiesces in, any such proceeding; or

(4) The levy of any distress, execution, or attachment upon the property of any Party which shall substantially interfere with its performance under this Agreement; provided that with respect to any Party, this form of insolvency shall not be deemed to have occurred if the insolvency is caused primarily by another Party's failure to make a payment due pursuant to this Agreement within forty-five (45) days of when it becomes due and payable.

(n) "Management Fee" has the meaning ascribed in Section 5.02.

(o) "Medical Staff" means the organized body of licensed physicians and other healthcare professionals, who are permitted by law to be members of the Medical Staff and who are approved and given privileges to provide health care to patients in the Hospital. Medical staff personnel may work full time or part time and may be employed by the Hospital or may be independent contractors or individuals employed by third-parties who are granted clinical privileges to practice.

(p) "Patient Records" means any Documents containing information concerning medical, health care or behavioral health services provided to, or the medical, health care or behavioral health of any individual, or that are otherwise subject to regulation under Applicable Laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HI TECH Act") and all regulations promulgated pursuant thereto, including the Transaction Code Set Standards, the Privacy Rules and the Security Rules set forth at 45 C.F.R. Parts 160 and 164.

(q) "Person" means any natural person or any entity including a corporation, limited liability company, limited partnership, partnership, joint venture, association, joint-stock trust, unincorporated organization, or government, agency or authority (including federal, State, county, municipal or other local agency) or political subdivision thereof.

(r) "Policies and Procedures" means any and all of the policies, procedures and directives in effect for the Hospital and, as applicable, the Hospital System on the Commencement Date, as the same may be amended and supplemented from time-to-time thereafter by HMC Parties after consultation with Manager.

(s) "Program Payors" means any governmental or non-governmental reimbursement program charged with paying claims for hospital or professional services rendered by the Hospitals to patients. including (i) any reimbursement under Medicare, Medicaid, and all other similar Federal, state or local reimbursement programs and (ii) any private insurance or other non-governmental reimbursement programs.

(t) "Services" means the managerial and other services provided by Manager for the Hospital and HMC Parties in accordance with this Agreement. For the avoidance of doubt, the Parties intend that, except for Additional Services, the Services shall be the same as those services are currently being provided to the Hospital as a constituent member of the Hospital System by the HMC Parties.

(u) "Service Fee" means the fee comprising the Management Fee and Incentive Fee.

(v) "State" means the State in which the Hospital is located.

(w) "Term" means the term of this Agreement comprising the Initial Term and, as applicable, the First Renewal Term, the Second Renewal Term, and the Third Renewal Term as set forth in Section 9.01.

(x) "Uncontrollable Circumstance" means any act, event or condition that prevents any Party from meeting, or materially increases the cost of performing, its obligations under this Agreement, if (i) such act, event or condition is beyond the reasonable control of the Party asserting an Uncontrollable Circumstance as justification for not meeting or performing such obligations, and (ii), with respect to Manager's obligations, such act, event or condition is not the result of Manager's failure to operate and maintain the Hospital in accordance with the terms and conditions of this Agreement. Subject to the immediately preceding provisions of this definition, the following acts, events or conditions may qualify as an Uncontrollable Circumstance:

(1) Flood, hurricane, tornado, epidemic, severe earthquake, catastrophic fire or explosion, act of a public enemy, war, blockade, insurrection, riot, general unrest, restraint of government and people, civil disturbance, sabotage or similar occurrence;

(2) The order, injunction or judgment of any federal, State or local court, administrative agency or governmental body or officer with jurisdiction over the Parties, including any exercise of the power of eminent domain, police power, condemnation or other taking by or on behalf of any public, quasi-public or private entity; provided that such order, injunction or judgment did not arise in connection with or is not related to the negligent or wrongful action or inaction of the Party relying thereon and provided further that neither the contesting in good faith of any such order, injunction, or judgment nor the reasonable failure to so contest shall constitute or be construed as a wrongful or negligent action or inaction of such Party;

(3) The suspension, termination, interruption, denial, failure to issue, modification or failure of renewal of any permit, license, consent, authorization or approval necessary to the operation, maintenance, repair and management of the Hospital; provided that such act or event did not arise in connection with, or is not related to, the negligent or willful action or inaction of the Party asserting an Uncontrollable Circumstance and provided further that neither the contesting in good faith of any such order nor the reasonable failure to so contest shall be construed as a negligent or willful action or inaction of such Party;

(4) Change in Law;

(5) The loss or inability to obtain any and all utility services, including electric power, necessary for the operation, maintenance, repair and management of the Hospital directly resulting in a partial or total curtailment of operations at the Hospital for reasons other than the negligent, willful or wrongful action or inaction of Manager;

(6) The failure of any subcontractor or supplier, other than a Party, to furnish services, materials, inventory or equipment on the dates agreed to; provided (1) such failure is the result of a Force Majeure, (2) such failure materially and adversely affects Manager's ability to perform its obligations and (3) Manager is not reasonably able to obtain substitute services, material, inventory or equipment on the agreed upon dates.

(7) An Uncontrollable Circumstance shall not include (i) any act, event or condition which is caused by the negligence or intentional action of the Party asserting the Uncontrollable Circumstance, its subcontractors, agents and employees, (ii) any event, reasonably foreseeable on the Commencement Date; (ii) economic infeasibility; (iii) any labor strike, work stoppage or slowdown on the part of Manager's employees, and (iv) subject to the definition of a Change in Law regarding changes in reimbursements rules and regulations or Conditions of Participation, any order, injunction or judgment of any federal, State or local court, administrative agency or governmental body interpreting federal, State, or local tax Laws.

SECTION 2

CONDITIONS PRECEDENT TO PARTIES' OBLIGATIONS

2.01 Satisfaction of Conditions. All rights and obligations of the Parties under this Agreement shall be subject to the satisfaction of the following conditions precedent:

(a) HMC Parties shall have delivered to Manager (i) a certificate of its Authorized Representative, dated as of the Commencement Date, to the effect that each of the representations of HMC Parties set forth in Section 10.01 of this Agreement is true and correct in all material respects as if made on such date and (ii) an opinion of counsel to HMC Parties, in customary form and reasonably acceptable to Manager, to the effect set forth in Sections 10.01 (a), (b), (c) and (d);

(b) Manager shall have delivered to HMC Parties (i) a certificate of its Authorized Representative, dated as of the Commencement Date, to the effect that each of the representations of Manager set forth in Section 10.02 of this Agreement is true and correct in all material respects as if made on such date and (ii) an opinion of counsel

to Manager, in customary form and reasonably acceptable to HMC Parties, to the effect set forth in Sections 10.02 (a), (b), (c) and (d).

(c) HMC Parties shall have received an independent broker's letter which certifies that all policies of insurance required to be obtained by Manager pursuant to this Agreement have been obtained;

(d) Manager shall have received an independent broker's letter which certifies that all policies of insurance required to be obtained by HMC Parties pursuant to this Agreement have been obtained;

(e) No action, suit, proceeding or official investigation shall have been overtly threatened or publicly announced or commenced by any Person in any federal, State or local court that (i) seeks to enjoin, assess civil or criminal penalties against, assess civil damages against or obtain any judgment, order or consent decree with respect to any Party as a result of the Parties' negotiation, execution, delivery or performance of this Agreement, or (ii) may, in the reasonable opinion of any Party, materially impair any other Party's ability to satisfactorily perform its obligations hereunder;

(f) No change shall have occurred on or before the Commencement Date in any Applicable Laws that would make the execution or delivery by any Party of this Agreement or that would make compliance by any Party with the terms and conditions of this Agreement, a violation of Applicable Laws;

(g) All of the documents, approvals or authorizations listed in this Section 2.01 shall be in full force and effect on the Commencement Date; and

(h) Contemporaneously with the execution of this Agreement, Manager shall enter into management agreements with HMC and each of the other Hospitals.

2.02 Satisfaction of Conditions. The Parties shall exercise good faith and due diligence in satisfying the conditions precedent identified in Section 2.01. Such conditions shall be satisfied or waived on or before the Commencement Date or no Party shall be liable to any other Party under this Agreement. In such case, each Party shall bear its respective costs and expenses attributable to the negotiation of the transactions herein contemplated.

SECTION 3

OBLIGATIONS AND RELATIONSHIP OF PARTIES

3.01 Independent Contractor.

(a) Nothing in this Agreement shall be deemed to constitute any Party a partner, employee or legal representative of any other Party. The Parties agree that Manager has entered into and shall be performing its obligations under this Agreement as an independent contractor.

(b) As an independent contractor, Manager has the sole right and responsibility to control and direct the means, manner and method by which its duties and obligations under this Agreement are performed and satisfied, including the right to enter into subcontracts with Affiliates or third-party vendors for the provisions of the Services pursuant to this Agreement. In

the event Manager enters into a subcontract to provide Services with a value of $10,000 or more, the subcontractor shall be required to provide access to its books, documents and records in accordance with this Agreement and Applicable Law. For the avoidance of doubt, any cost and expense associated with a subcontract shall not be a Hospital Expense.

(c) To the extent permitted pursuant to this Agreement and Applicable Law, Manager may, from time to time, act as the agent of HMC Parties, and in so acting, shall possess the apparent and actual authority to act or speak for HMC Parties in accordance with this Agreement and Applicable Law; provided that Manager shall not by words, acts or representations convey to the general public, any Person or any governmental unit the impression that Manager has any other authority or power, and the Parties shall take any action necessary to correct any such erroneous inferences and to prevent reliance on such a mistake of fact.

3.02 Not Related Parties. Manager and HMC Parties are not (and shall not become) related parties to one another and do not have (and shall not have) overlapping members on their respective governing bodies. In addition, neither of the Parties has (and shall not have) any voting power or control over another Party's governing body or officers, directors, managers, shareholders and members.

3.03 Medical Judgments. By entering into this Agreement, HMC Parties do not delegate to Manager any matters requiring professional medical judgments, and all such matters shall be the responsibility of the Medical Staff or other health professionals. Manager shall not be responsible for, nor have any right to make, judgments regarding the delivery of medical care by physicians or other health professionals.

3.04 Governance.

(a) During the Term, HMC shall maintain in office one or more executive officers who are authorized by, and accountable to, the Board of Directors for (i) the day-to-day management of those portions of HMC's business that are not delegated to Manager under this Agreement, (ii) the supervision of the performance and implementation of HMC Parties' duties and responsibilities under this Agreement, and (iii) the performance all other customary duties and responsibilities of executive officers under Delaware law.

(b) HMC Parties shall retain all authority vested exclusively in them by Applicable Laws and accreditation standards, and Manager shall undertake only such activities under this Agreement as are permitted by Applicable Law and accreditation standards. The Boards of HMC Parties shall represent the Hospital in matters pertaining to the interpretation of this Agreement; provided that in any situation in which the Boards of HMC Parties shall be required or permitted to take any action or to give any approval, Manager may rely upon the written statement of the Authorized Representative of HMC Parties to the effect that any such action or approval has been taken or given.

(c) Whenever any action shall be subject to the approval of the Boards of HMC Parties, to the extent possible, Manager shall be entitled to receive a decision within five (5) business days or such shorter period as necessary to ensure compliance with Applicable Laws after notification of the proposed action shall have been made available to the Authorized Representative of HMC Parties.

(d) Each Party shall invite the other Parties' Authorized Representative(s) to attend all meetings of such Party's Board, and the committees thereof, in a non-voting observer capacity and, shall make available to the Authorized Representative copies of all notices, minutes, consents and other Board or committee materials that it provides to its directors, managers or committee members; provided that in no event shall the failure to provide the notice described above invalidate in any way any action taken at a meeting of the Board of a Party or any committees thereof. Each Party reserves the right to withhold any information and to exclude another Party's Authorized Representative from any meeting, or any portion thereof, as is reasonably determined by the Party to be necessary for purposes of confidentiality, competitive factors, attorney-client privilege or other reasonable purposes. For the avoidance of doubt, the Parties acknowledge and agree that they are not fiduciaries to one another and that any participation by a Party in the other Party's Board meetings shall only be advisory in nature and shall not deemed to be an exercise of any control over the decisions made by the applicable Board.

3.05 Payment of Hospital Expenses. HMC Parties shall pay, make funds available to Manager for the payment of, or otherwise cause to be satisfied or discharged, all Hospital Expenses when due under their terms (and prior to the implementation of any penalties); provided that either HMC Parties, in their own name, or Manager, in the name and behalf of HMC Parties, may contest in good faith the payment of any Hospital Expenses. In the event of any such contest, any such Hospital Expense may remain unpaid during the period of the contest and any appeal therefrom. The Parties will cooperate fully with one another in any such contest or appeal. The costs incurred by the Parties in any such contest or appeal shall be a Hospital Expense. Any material increase in Manager's cost to perform the Services resulting from a Change in Law shall be subject to HMC Parties Board approval.

3.06 No Financing Transactions. Except as otherwise permitted by this Agreement, Manager shall not engage in any financing transactions that result in liens, mortgages, lines of credit or security interests in the name of the Hospital or HMC Parties without the advance written consent of HMC Parties, which may be withheld in HMC Parties' sole discretion. Prior to requesting consent for approval, Manager shall provide a term sheet to HMC Parties describing the amount of required financing, the purpose of the financing, a rate-of-return analysis forecasting sufficient revenue to repay the financing, and other reasonable financing alternatives, if any. Manager shall not, under any circumstance, pledge the credit of HMC Parties or the revenues of the Hospital, nor shall Manager in the name of or on behalf of HMC Parties borrow any money or execute any promissory note other obligation, or dispose of any asset of the Hospital other than in the ordinary course of business, without the prior written consent of HMC Parties.

3.07 Limitations on Dividends and Other Distributions. During the Term, except as otherwise provided for in the Final Confirmation Order, HMC Parties shall not pay any dividends or make any other distributions to its shareholders and/or members incident to their ownership of shares of stock and/or membership interests in HMC Parties unless HMC Parties are current on all payments of the Service Fee to Manager in accordance with this Agreement, and notwithstanding that HMC Parties are current on all payments of the Service Fee to Manager in accordance with this Agreement, if the making of any such payment will render the HMC Parties unable to make any payment of the Service Fee in accordance with this Agreement when the same becomes due.

SECTION 4

PROVISION OF SERVICES

4.01 Overall Responsibilities of Manager. On and after the Commencement Date and through the Term, Manager shall, in accordance with this Agreement, Applicable Laws and applicable industry standards shall, on a exclusive basis, provide or arrange for the provisions of the following Services:

(a) Professional, reliable and cost effective management and supervision of the Hospital that is, to the extent practicable, consistent with the Hospital's participation in the Hospital System;

(b) Human resources services to Hospital Personnel;

(c) General accounting functions for the Hospital, billing, collection, reimbursement and revenue cycle functions for the Hospital including acting on HMC Parties' behalf with respect to contracting with Program Payors, and accounts payable functions with respect to Hospital operations including the payment of the Service Fee, any Additional Payments, or other payments due to Manager in accordance with this Agreement;

(d) Maintenance and retention of all Patient Records and other records of the Hospital;

(e) Maintenance, generation, filing and provision to the appropriate Persons in a timely manner all information, notices, reports and records, as may be required of the Hospital pursuant to Applicable Laws, as expeditiously as possible after the requisite information is made available to Manager but in no event later than the applicable date specified in this Agreement or that which may be reasonably required under the circumstances to make appropriate filings or to give appropriate notices in a timely manner;

(f) Evaluation of proposed, pending or final regulatory changes from an operational standpoint to determine their effect on the Hospital's operations and the Policies and Procedures;

(g) Assistance to HMC Parties in responding to requests for information from external financial auditors and others, including federal, State and local audits and information requests, permit compliance reports, information requests from users or groups of users of the Hospital, and information requests from communities that are provided healthcare services by the Hospital;

(h) Maintenance and support of professional and responsive working relationships with the Authorized Representative of HMC Parties and the Medical Staff, local, State and federal regulatory authorities, suppliers of materials, the media and the public, and the local community and advisory board of the Hospital;

(i) Advice and assistance to HMC Parties in instituting legal action or proceeding reasonably necessary for the operation of the Hospital, or in defending any legal action or proceeding brought against HMC Parties or the Hospital, except legal actions between the Parties;

(j) Maintenance and updating of the Policies and Procedures on an as-needed basis and as required by Applicable Laws;

(k) Advice and assistance to HMC Parties in the preparation of monthly unaudited and annual audited financial statements of the Hospital to HMC Parties;

(l) Support to HMC Parties in connection with its long-term and short-term planning and implementation of Capital Projects and any Additional Services related thereto; and

(m) Provide to HMC Parties unlimited access to the Hospital and its facilities and to Patient Records and other records of the Hospital and/or the Hospital System. It is acknowledged and agreed by the Parties that all such records shall be and remain the property of HMC Parties.

4.02 Overall Responsibilities of HMC Parties. On and after the Commencement Date and during the Term, HMC Parties shall, in accordance with this Agreement and Applicable Laws:

(a) Pay, or cause to be paid, the Service Fee, any Additional Payments or other payments due to Manager in accordance with the terms of this Agreement;

(b) Pay, make funds available to Manager for the payment of, or otherwise cause to be satisfied or discharged, all Hospital Expenses in accordance with the terms of this Agreement;

(c) Retain oversight and responsibility for policy guidance of the Hospital;

(d) Employ and provide all Hospital Personnel (other than the CEO) needed to staff the Hospital at a level sufficient to ensure the safe and efficient operations;

(e) Implement, or cause to be implemented, such Capital Projects relative to the Hospital as HMC Parties, in their sole discretion, deem necessary or appropriate;

(f) Provide Manager with unlimited access to the Hospital and its facilities and to Patient Records and other records of the Hospital and/or the Hospital System as may be necessary or convenient to permit Manager to perform its obligations under this Agreement; provided, however, it is acknowledged and agreed by the Parties that all such records shall be and remain the property of HMC Parties;

(g) Maintain and keep, with the cooperation and assistance of Manager, in force all applicable federal, State and local certifications, regulatory, licenses and permit requirements and any subsequent modifications with respect to the Hospital;

(h) Pay all taxes assessed and due with respect to the Hospital;

(i) Make available to Manager, warranty information, engineering drawings, calculations, maintenance manuals, operational records, logs, reports, relating to the design, condition, operation or maintenance of the Hospital; and

(j) Assist Manager with the purchase of, and pay for, all equipment and inventory and other tangible personal property to be used in the operation, maintenance, and capital improvements to the Hospital.

4.03 Strategic Planning and Budgeting.

(a) Prior to the preparation of the annual budget, Manager shall prepare and submit to HMC Parties for their review and approval, the strategic plan containing recommendations for the Hospital's short and medium-range goals and objectives. By way of illustration, such plan may include recommendations concerning the type and scope of services provided at the Hospital, the means by which such services are provided, and proposed modifications to the Hospital's facilities and equipment. It is acknowledged and agreed by the Parties that, to the extent practicable, the strategic plan for the Hospital shall be consistent with the strategic plans for the Hospital System.

(b) At least forty-five (45) days before the end of each Fiscal Year, Manager shall prepare and submit to HMC Parties for their review and approval, a proposed annual operating budget, annual capital expenditures budget, and annual cash flow projections of the Hospital for the next Fiscal Year. Manager shall, on an on-going basis, suggest appropriate revisions to the budget to reflect material changes during the course of each Fiscal Year. Once HMC Parties have approved an annual budget and any appropriate revisions thereto ("Approved Budget"), Manager shall be authorized to proceed with expenditures contemplated by the Approved Budget without the need for further approval by HMC Parties.

4.04 Management Reports and Meetings. No less frequently than once each Billing Quarter during the Fiscal Year, Manager shall meet with the Authorized Representative of HMC Parties to discuss and review the status of the Hospital's operations. Manager shall prepare and circulate an agenda at least three (3) business days prior to such meeting and, within fifteen (15) days following the meeting, a summary report detailing the matters discussed and agreed upon follow-up action. No later than ninety (90) days following the end of each Billing Year, Manager shall submit to the Authorized Representative of HMC Parties a detailed and comprehensive report addressing the operational status of the Hospital during such Billing Year.

4.05 Authority to Purchase and Contract; Limitations.

(a) To the extent contemplated by the Approved Budget, Manager shall have the responsibility and authority to (i) enter into, perform, and carry out on behalf of and in the name of HMC Parties, any and all accounts, contracts, leases, agreements or other documents that are, in the reasonable business judgment of Manager, necessary or desirable to facilitate the efficient delivery of the Services and (ii) amend, extend, modify, or terminate any such account contract, lease, agreement, and other documents. To the extent possible, all agreements entered into by Manager pursuant to this Agreement shall be freely assignable to either or both of HMC Parties. Any purchase or contract by Manager made pursuant or otherwise ancillary to this Agreement shall be a Hospital Expense.

(b) Manager shall have the responsibility and authority to contract with such special consultants as Manager, from time-to-time, deems desirable. Each such contract shall be on behalf of, in the name of and at the expense of HMC Parties, and shall be subject to the prior written approval of HMC Parties only if the contract amount is not included in the Approved

Budget and will result in a Hospital Expense greater than $250,000 for each individual unbudgeted item or in the aggregate for all unbudgeted items in any Fiscal Year. Consultants shall be deemed to be retained as independent contractors by HMC Parties.

(c) HMC Parties agree that Manager, or an Affiliate of Manager, may be chosen as a vendor, lessee or contracting party for any purpose contemplated by this Agreement; provided that any product or service purchased or leased from Manager, or an Affiliate of Manager, must be (i) granted on a competitive basis or (ii) priced at market rates and approved in advance by HMC Parties if the contract amount is not included in the Approved Budget and will result in a Hospital Expense greater than $250,000 for each individual unbudgeted item or in the aggregate for all unbudgeted items in any Fiscal Year.

(d) Manager shall not have the authority to enter into, perform, and carry out any account, contract, lease, agreement or other document if the amount thereof (i) is not included in the Approved Budget and will result in a Hospital Expense greater than $250,000 for each individual unbudgeted item or in the aggregate for all unbudgeted items in any Fiscal Year, or (ii) is for the lease or purchase capital assets that are not a part of the current Approved Budget, without the prior written approval of HMC Parties.

(e) Nothing in this Agreement shall authorize Manager, without the prior written consent of HMC Parties (which may be withheld in HMC Parties' sole discretion but shall be deemed granted by inclusion of an item in the Approved Budget), to enter into any contract, commitment or transaction not in the usual and ordinary course of the business of the Hospital, utilize the assets of the Hospital for any purpose other than the continued operation of the Hospital, distribute any of the assets of the Hospital to Manager or any other person or entity, or dispose of, transfer, convey, pledge, mortgage, encumber or otherwise subject to any lien or security interest any of the assets of the Hospital.

(f) The Parties acknowledge and agree that Manager is not a merchant and accordingly, MAKES NO WARRANTY, EXPRESSED OR IMPLIED INCLUDING, WITHOUT LIMITATION, THAT OF FITNESS FOR A PARTICULAR PURPOSE OR MERCHANTABILITY IN RESPECT OF THE SUPPLIES, EQUIPMENT AND OTHER GOODS AND SERVICES PURCHASED ON BEHALF OF THE HOSPITAL OR HMC PARTIES. The terms used in this Section 4.05(f) are defined in each particular instance by the Uniform Commercial Code as enacted in the State in which the Hospital is located.

4.06 Accountants; Financial Statements.

(a) Manager shall provide assistance to HMC Parties in (i) retaining a firm of independent certified public accountants ("CPA") approved by HMC Parties, (ii) assembling the information required to prepare HMC Parties' Fiscal Year financial audit for the Hospital and the Hospital System, and (iii) responding to the management representation letter regarding any findings or any recommendations made by the CPA.

(b) In consultation with the CPA, Manager shall establish and administer accounting procedures and controls and systems for the development, preparation and safekeeping of records, assets, and books of account relating to the business and financial affairs of the Hospital in its role as a constituent member of the Hospital System.

(c) In consultation with the CPA and within the guidelines of generally accepted accounting principles ("GAAP"), Manager shall make decisions as to accounting principles and elections, whether for book or tax purposes; provided that Manager shall not, without the prior written consent of HMC Parties, which may be withheld in HMC Parties' sole discretion, change the nature of the business of the Hospital as currently conducted, or change the accounting methods or practices with respect to the Hospital.

(d) HMC Parties shall have the right at all reasonable times during the usual business hours of Hospital and upon demand to audit, examine, and make copies of books of account and similar records maintained by Manager applicable to the Hospital or the Hospital System.

(e) At all times, Manager shall keep HMC Parties informed of the financial condition and operation of the Hospital and provide such reports in such form and with such content as HMC Parties may reasonably request, including the following reports to be prepared in consultation with the CPA and delivered to HMC Parties:

(1) Within forty-five (45) days after the close of each month, the unaudited and consolidated financial statements of the Hospital and the Hospital System for the preceding month and the Fiscal Year to date; and

(2) Within one-hundred twenty (120) days following the last day of each Fiscal Year, the audited and consolidated financial statements of the Hospital and Hospital System for the Fiscal Year ended.

4.07 General Accounting and Revenue Cycle Functions.

(a) Manager shall use the information technology systems being utilized by the Hospital and the Hospital System on the Commencement Date, or such other systems that the Parties by mutual agreement may designate from time-to-time during the Term. Manager shall use its best efforts to ensure that all such systems operate in a manner consistent with all Applicable Laws and any third-party payor requirements. It is acknowledged and agreed by the Parties that HMC Parties have entered into binding commitments to replace the existing information technology systems with the NEXTGEN Healthcare systems,

(b) Manager shall manage the complete revenue cycle of the Hospital including registration of patients, preparation and delivery of patient bills, generation and delivery of past due patient bills, receipt of revenues and deposits; debt collection, responding to and processing patient inquiries and requests, correction of billing errors, disbursement or application of revenues and deposits, informing patients of their rights and responsibilities, adding and deleting accounts, recordkeeping, database maintenance, and all other financial services, using the Policies and Procedures in effect for the Hospital and the Hospital System on the Commencement Date.

(c) Manager shall provide the Hospital with CMS and other third-party payor reimbursement services including arranging on behalf of HMC Parties for the preparation and filing of cost reports, coordinating the fiscal intermediary audits of such cost reports, assisting with the appeal of audit adjustments by fiscal intermediaries to such cost reports, maintaining and updating the accounting system including accounting entries to record cost reports, monitoring and implementing legislative and regulatory changes to third-party reimbursement, and monitoring third-party payor cash flow.

(d) Manager shall manage the accounts receivable of the Hospital, including government patient receivables and other patient and third-party payor receivables, and cost report settlements arising from Hospital's rendering of services to patients, billed and unbilled, recorded or unrecorded, accrued and existing, using the Policies and Procedures in effect for the Hospital and the Hospital System on the Commencement Date. Manager shall use its best efforts to ensure that all funds are collected and expended for the payment of and on behalf of the Hospital, and shall notify HMC Parties promptly if insufficient funds exist or funding is projected to be insufficient.

(e) Manager shall make, or direct to be made, timely deposits of all receipts and moneys arising from the operation of the Hospital in accordance with the Policies and Procedures in effect for the Hospital and the Hospital System on the Commencement Date. Deposits shall be made in such interest bearing or non-interest bearing accounts (including lock box accounts) as may be designated by HMC Parties, from-time-to time, in such banks, savings and loan associations, and other financial institutions as HMC Parties may from time-to-time select. Consistent with the operations of the Hospital System as an operationally unified and financially consolidated business, the funds of the Hospital may be comingled with the funds of the other hospitals and clinics in the Hospital System. The funds of the Hospital may not be comingled with the funds of Manager.

(f) Manager shall exercise reasonable care in applying the Hospital's collections to the timely payment of Hospital Expenses. Manager may make disbursements from such accounts on behalf of HMC Parties in such amounts and at such times as the same are required to operate the Hospital and the Hospital System in accordance with the Approved Budget and Policies and Procedures in effect from time-to-time. Manager shall establish the signatories and approvals as to the amounts on all checks subject to the review and approval of HMC Parties.

4.08 Continuation of Benefits Program; Human Resources Functions.

(a) The Parties acknowledge and agree that, to the extent practicable, the employee benefit program in effect for the Hospital System on the Commencement Date (the "Benefits Program") shall be continued under this Agreement with such endorsements, amendments and supplements as necessary to reflect the requirements of this Agreement.

(b) Manager shall supervise and direct the day-to-day work activities of Hospital Personnel and shall determine the qualifications and the number (FTEs) of Hospital Personnel required for the safe and efficient operation of the Hospital and shall establish and revise wage scales, employee benefit packages, in-service training programs, staffing schedules, and job descriptions for Hospital Personnel.

(c) Manager shall have the authority: (i) to negotiate, execute and terminate employment contracts with physicians and other healthcare professionals, and (ii) to hire, discipline and terminate Hospital Personnel. The termination of employment agreements and Hospital Personnel must be approved in writing in advance by HMC Parties' Authorized Representative; provided that in emergent circumstances, Manager shall have the authority to termination any employment agreement and Hospital Personnel as Manager deems necessary or prudent for the safe and efficient operation of the Hospital, and all such emergent terminations shall be final and not subject to the review and approval of HMC Parties.

(d) Manager shall, at its own cost and expense, provide the Hospital with the services of a hospital administrator, who shall serve as the chief executive officer ("CEO") of the

Hospital. Manager shall employ the CEO and shall pay his salary and benefits. Hospital Personnel shall be under the direct supervision and control of the CEO, and the CEO shall be under the direct supervision and control of Manager.

(e) To the extent permitted by law, prior to employing any newly hired Hospital Personnel, Manager must request and obtain from such employee detailed information concerning such employee's qualifications and ability to perform the position for which such employee is applying. Manager shall provide newly hired Hospital Personnel with an orientation and shall conduct interviews, employee performance assessments, and initial ninety (90)-day performance reviews.

(f) Manager shall provide training for all Hospital Personnel involved in providing the Services. Manager shall ensure that all training of Hospital Personnel is continually updated on a scheduled basis, and that all Hospital Personnel shall be recertified or relicensed, as applicable, as required or as recommended pursuant to Applicable Laws. It is the sole responsibility of Manager to ensure that all Hospital Personnel are fully knowledgeable of his or her duties and responsibilities. HMC Parties reserve the right to inspect, review and monitor any and all training conducted by Manager. This includes inspection and review of all training materials, interviews with all training personnel, and monitoring of all training classes. Each individual employee's training needs will be assessed against qualifications and experience required for each job description. Job skills enhancement training shall be provided by Manager at all levels. The training shall continue throughout the Term.

(g) Manager shall not unlawfully discriminate against any worker, employee or applicant, or any member of the public and shall comply with federal, State or local law. Manager shall take affirmative steps to ensure that applicants are considered for employment, and that Hospital Personnel are dealt with during employment, without regard to their race, color, religion, gender, national origin, age, disabled veteran or Vietnam-era veteran status. Such affirmative steps shall apply to, but not be limited to, the following: hiring, promotion, demotion or transfer; recruitment or recruitment advertising; layoff or termination, or rates of pay or other forms of compensation; and selection for training, including apprenticeship.

4.09 Safety of Persons and Property. On and after the Commencement Date and through the Term, Manager shall comply with all Applicable Laws that relate to the safety of Persons or property with respect to the Hospital and their/its protection from damage, injury or loss, and shall designate a qualified and responsible representative of Manager whose duties shall include safety and the prevention of medical errors, fires and accidents and to coordinate such activities as shall be necessary with federal, State, and other local officials.

4.10 Medical Staff and Professional Matters. The Medical Staff shall be organized and function according to the Hospital's Medical Staff bylaws, as amended from time-to-time, subject to review and approval of HMC Parties. Manager shall assist HMC Parties with respect to development and maintenance of Medical Staff relations and coordinating the duties of the Medical Staff. Manager shall oversee the Medical Staff's administrative affairs, including monitoring the performance of professional services by the Medical Staff and other healthcare professionals to ensure that the Hospital maintains high standards of patient care, treatment and related functions. Manager shall also assist and direct the Hospital and the Medical Staff in updating and revising its Medical Staff bylaws, and in the privileging and credentialing process. The foregoing notwithstanding, HMC Parties retain control and authority over all appointments to the Medical Staff, the granting of clinical privileges at the Hospital, and any actions taken with respect to Medical Staff members, including appeals of adverse actions in accordance with the

Medical Staff bylaws. HMC Parties may at any time revoke Manager's authority to oversee Medical Staff affairs, appointments and actions at the Hospital.

4.11 Physician Recruitment. Manager shall use its best efforts to recruit, as-needed, additional physicians to become members of the Medical Staff. Recruited physicians shall meet such criteria as established by Manager, in consultation with HMC Parties and the Medical Staff. Any cost incurred in the recruitment of such physicians relating to income guarantees, moving expenses, travel expense or other similar type expenses shall be incurred in accordance with the Approved Budget and shall be a Hospital Expense.

4.12 Quality Assurance, Legal Compliance and Risk Management. Manager shall continue, and carry out the day-to-day implementation of, the quality assurance and quality control, legal compliance and risk management programs, and the Policies and Procedures related thereto, in effect for the Hospital System on the date of this Agreement, as the same may be amended and supplemented from time-to-time with the consent of HMC Parties.

4.13 Compliance with Applicable Laws and Policies and Procedures; Emergent Circumstances.

(a) Manager shall operate the Hospital in compliance with Applicable Laws and using the Policies and Procedures in effect for the Hospital and the Hospital System on the Commencement Date. Any material deviation from the Policies and Procedures must be approved in writing in advance by HMC Parties; provided that in emergent circumstances, Manager shall have the authority to establish such Policies and Procedures as Manager deems necessary or prudent for the operation of the Hospital. All such emergent Policies and Procedures shall remain subject to the final review and approval of HMC Parties.

(b) If Manager demonstrates its compliance with this Agreement, Manager shall not be liable for payment for any fines or civil penalties imposed by any federal, State or local court or governmental regulatory and permitting agencies having competent jurisdiction. If however the imposition of such fines and penalties is due to (i) Manager's negligent act or omission, (ii) its willful or wrongful action or inaction, or (iii) its failure to meet or demonstrate its compliance with the requirements of this Agreement, Manager shall be solely liable for the payment of any such fine, civil penalty or damage as a consequence of action or failure.

(c) If Manager shall become aware of any event, activity, problem or circumstance relative to the operation of the Hospital that threatens or may threaten the public health, safety or welfare of the patients or employees of the Hospital, Manager shall immediately take all necessary and appropriate actions to correct and mitigate such situation and make such notifications as required by the circumstances and/or by Applicable Laws. Manager shall immediately notify HMC Parties. If prior authorization from HMC Parties cannot be obtained in a timely manner under the circumstances, Manager shall make such necessary and reasonable expenditures to comply with its obligations under this Agreement. All such expenditures shall be reimbursed to Manager as a Hospital Expense.

4.14 Inspections. HMC Parties shall through their representatives and agents, with the full cooperation of Manager, without prior written or oral notice, and on a twenty-four (24) hour per day, seven (7) days per week basis, have full access to and the unlimited right to inspect the Hospital to determine whether Manager is in compliance with all of its obligations under this Agreement. All expenditures incurred by HMC Parties related to such inspections shall be a Hospital Expense.

4.15 Maintenance. During the Term, Manager shall perform, or arrange for the performance of, all corrective, predictive, preventive, periodic and routine maintenance or repair of the Hospital and equipment. Such maintenance and repair shall not be less frequent and comprehensive than that recommended or specified in manufacturer's warranties. Manager shall cooperate and assist HMC Parties to enforce equipment warranties. All expenditures incurred by Manager with respect to such maintenance and repair and warranties enforcement, shall be a Hospital Expense.

4.16 Capital Projects.

(a) The Parties recognize and agree that they must coordinate their activities related to Capital Projects such that the activities can be accomplished in an efficient and timely manner while permitting Manager the ability to comply with its duties and obligations under this Agreement. In order to ensure such coordination, Manager shall have the exclusive right, and the obligation, to provide to HMC Parties the work and activities related to the implementation all Capital Projects and any other Additional Services related thereto.

(b) Within ninety (90) before the end of each Billing Year, the Parties shall develop a plan for Capital Projects for the next Fiscal Year and estimate of the costs associated therewith. HMC Parties shall determine which Capital Projects shall be done, and when those Capital Projects shall be implemented. If HMC Parties implement a Capital Project, the Parties shall implement the Capital Project upon mutually agreeable terms, and HMC Parties shall provide Additional Payments to Manager for the Capital Project and any other Additional Services related thereto.

(c) All Capital Projects shall become and remain the property of HMC Parties beginning with the earlier of the date they are procured, implemented or installed. Manager hereby covenants and warrants that Manager shall not have any lien, security or other ownership interest in the Hospital, a Capital Project, or any part thereof, and hereby waives, now and forever, any lien, security or other ownership interest it may or could otherwise have or allege to have under any Applicable Laws, to any part of the Hospital or Capital Projects.

4.17 Management of Additional Hospitals and Clinics. Manager shall have the exclusive right, and the obligation, to provide Services, under and pursuant to the terms and conditions of this Agreement, to any additional hospitals and clinics that are purchased or otherwise acquired by HMC Parties in transaction involving a Change or Control or otherwise.

4.18 Evaluation of Full Staffing Model. After the Commencement Date, the Parties shall undertake to evaluate the feasibility of Manager employing the Hospital Personnel instead of CAH11. If the Parties agree to proceed, this Agreement shall be modified or amended accordingly including, among other things, an increase in the Service Fee by an amount equal to the aggregate costs to Manager to provide the services that the former Hospital Personnel will provide as employees of Manager plus a reasonable profit margin. For the avoidance of doubt, the final decision regarding whether Manager will employ Hospital Personnel shall, at all times, remain in the sole discretion of the Parties.

SECTION 5

SERVICE FEE

5.01 Service Fee. The Service Fee shall be the sum of the Management Fee and the Incentive Fee.

5.02 Management Fee; Payment; Adjustments.

(a) For any Billing Year, the Management Fee shall be the greater of (i) $1,420,000 (the "Minimum Management Fee"), or (ii) an amount equal to eleven (11%) percent of the Cash collected during the Billing Year, as the same is shown in the Fiscal Year financial audit of the Hospital and the Hospital System for the Billing Year. For purposes of the foregoing calculation, the parties agree that Cash collected during the Billable Year shall not include any amounts paid by CMS for 2011 and 2012 cost report settlements pursuant to the HMC Parties' Plan of Reorganization regardless of when such payments are received.

(b) For each Billing Month during any Billing Year, HMC Parties shall pay to Manager an amount equal to one-twelfth ($1/12^{th}$) of the Minimum Management Fee. The Minimum Management Fee shall be billed on the first (1^{st}) day of each Billing Month and shall be paid by the fifteenth (15^{th}) day of the same Billing Month.

(c) If the Audited Financial Statements for any Billing Year show that the Management Fee for the Billing Year is greater than the Minimum Management Fee paid to Manager, HMC Parties shall pay such greater amount to Manager within thirty (30) days after the delivery of the Audited Financial Statements to HMC Parties.

(b) The Management Fee shall be adjusted annually (up or down) commencing with the second Billing Year, by an amount equal to the product of the Management Fee for the current Billing Year times the annual change in the CPI; provided that in no event shall any downward CPI adjustment reduce the Management Fee below the Minimum Management Fee.

5.03 Incentive Fee; Calculation and Payment.

(a) For any Billing Year, the Incentive Fee shall be equal to an amount not to exceed Twenty-five (25%) of the Minimum Management Fee for such Billing Year (the "Maximum Incentive Fee"). For each Billing Year, the Incentive Fee shall be calculated based on the mutual assessment of the performance of Manager with respect to incentive criteria with associated:

(i) The quality improvement measures set forth on Exhibit 5.03, all of which measures have been mutually agreed to by the Parties as of the Commencement Date; and

(ii) The financial performance measures to be agreed upon by the Parties in good faith within one hundred eighty (180) days after the Commencement Date.

The Parties further acknowledge and agree that (x) the quality improvement measures set forth on Exhibit 5.03 shall act as the threshold requirement or trigger for the calculation of the Incentive Fee based upon the financial performance measures; (y) the financial performance measures shall be divided into various subcomponents that will be assigned weighted percentages; and (z) HMC Parties shall pay Manager the Incentive Fee based upon the total

percentage obtained by adding the percentages attributable to each subcomponent that is fully satisfied by Manager.

(b) Within forty-five (45) days of the last day of each Billing Year, HMC Parties shall provide Manager a report which sets forth (i) the final assessment by HMC Parties of each of the performance measures used in computing the Maximum Incentive Fee for the preceding Billing Year and (ii) the amount of Incentive Fee to which Manager shall be entitled for such Billing Year based on such assessment. Manager shall have thirty (30) days after the assessment report is made available to Manager to object to the Incentive Fee as assessed by HMC Parties. If Manager does not dispute the assessment report prior to the expiration of such period, then the Incentive Fee as assessed by HMC Parties shall be deemed final, and shall be paid to Manager within ten (10) days thereafter.

5.04 Resolution of Incentive Fee Disputes.

(a) The Authorized Representatives of the Parties shall serve as an ad hoc dispute resolution committee for the purpose of resolving in a timely and effective manner any disputes that may arise regarding the agreement of the Parties upon the financial performance measures of the Incentive Fee, or the calculation or assessment of the Incentive Fee by the Parties under Section 5.03.

(b) The ad hoc committee shall meet as often as the circumstances may deem necessary to discuss and resolve any disputes that may arise from the calculation or assessment of the Incentive Fee for the Billing Year then in progress. To the extent the committee, after good faith attempts, cannot resolve a dispute, any Party may upon written notice ("Dispute Notice") refer the dispute to a single arbitrator ("Arbitrator") in accordance with the following terms:

(1) Manager and HMC Parties shall agree upon an individual to act as the Arbitrator of their dispute. If the Parties cannot agree upon the Arbitrator, each shall select an arbitrator, put such arbitrator's name on a slip of paper and place it in a receptacle. A representative of one of the Parties shall draw one slip of paper from the receptacle and the arbitrator whose name is on such slip of paper shall hear and decide the Parties' dispute. The determination to be made by the Arbitrator shall be limited solely to whether or not an Incentive Fee should be paid to Manager and, if so, the amount to be paid.

(2) The Arbitrator shall be appointed by the Parties within five (5) business days after giving of the Dispute Notice. Within ten (10) days following such appointment, each Party shall make available to the Arbitrator their respective statements as to whether an Incentive Fee is due to Manager, and if so, an estimate of the amount to be paid. The Arbitrator shall within thirty (30) days thereafter render his written decision as to whether or not an Incentive Fee is due to Manager, and if so, the amount to be paid.

(3) The decision of the Arbitrator shall be final and binding upon the Parties. The cost of the Arbitrator shall be paid by Manager and HMC Parties equally.

(c) The Parties shall continue to perform their respective obligations under this Agreement, without interruption or slowdown, pending resolution of any dispute. This Section 5.05 shall survive termination or expiration of this Agreement.

5.06 Compliance with Applicable Laws; Service Fee Renegotiation.

(a) Notwithstanding anything else to the contrary provided for herein, payment of the Service Fee, or any part thereof, shall be made in a manner that is in compliance with Applicable Laws, and where necessary any payment of the Service Fee, or any part thereof, will be deferred or adjusted to ensure such compliance. It is acknowledged and agreed by the Parties that any such deferral or adjustment shall constitute an Uncontrollable Circumstance on behalf of Manager.

(b) The Service Fee, or any part thereof, may need to be renegotiated on and after the Commencement Date based on the occurrence of an Uncontrollable Circumstance or as a result of catastrophic damage to the Hospital. The Parties agree to use their best efforts to renegotiate the Service Fee, or any part thereof, to reflect such occurrence. If, during any Billing Month, an Uncontrollable Circumstance shall occur or catastrophic damage to the Hospital shall occur, Manager shall exercise its best efforts to reduce operations and maintenance expenses, and shall within three (3) days meet with HMC Parties to discuss adjustments to the Approved Budget and measures Manager shall take to give effect to this Section 5.06. Manager shall, as soon as practicable under the circumstances, make available to HMC Parties with a report itemizing the measures to be taken, an analysis of the financial impact of such occurrence, if any, and the adjustment, if any, recommended to the Service Fee, or any part thereof.

SECTION 6

INSURANCE

6.01 Continuation of Insurance Program. The Parties acknowledge and agree that, to the extent practicable, the insurance program in effect for the Hospital System on the date of this Agreement (the "Insurance Program") shall be continued under this Agreement with such endorsements, amendments and supplements the requirements as necessary to reflect the requirement of this Agreement.

6.02 HMC Parties' Insurance Obligation. At all times during the Term, HMC Parties shall keep in full force and effect policies of insurance of the type, extent, amount and cost of coverage which are consistent with sound management of the Hospital, insuring HMC Parties, Manager and the Hospital against the risks customarily insured by such a facility including, without limitation, professional liability insurance with limits no less than the limits in effect with respect to the policies comprising the Insurance Program. The cost of such insurance shall be a Hospital Expense. Manager shall, from time-to-time, make recommendations to HMC Parties with respect to the Insurance Program and will timely obtain and submit to HMC Parties proposals for the renewal, amendment or replacement thereof.

6.03 Manager's Insurance Obligation. Manager shall keep in full force and effect such policies of insurance as are appropriate to insure HMC Parties and their employees and agents against any liability resulting from Manager or Manager's employees' acts or omissions with limits no less than the limits for such policies in effect on the date of this Agreement. The cost of such insurance shall be at Manager's sole cost and expense.

6.04 Duty to Maintain; Continuous Coverage. Each Party shall secure its respective policies prior to the Commencement Date and shall continuously maintain such policies through the Term. Manager shall assure continuous coverage if any Manager's Policy is canceled, not

renewed or materially changed. Manager shall take all steps necessary to assure no lapse of coverage for any time period.

6.05 Deductibles. Each Party shall be solely responsible to satisfy any and all deductibles and self-insured retentions contained in its insurance coverages as well as any excluded loss or losses if the same are within such Party's liability under this Agreement. If any Party desire higher deductibles on policies other than workers compensation, it must first obtain the prior written consent of the other Parties, which consent may be withheld in a Party's sole discretion.

6.06 Certificates as Evidence of Insurance. Copies of the policies referred to in Sections 6.02 and 6.03 shall be furnished to the Parties prior to the Commencement Date for review and approval. If any policy is for any reason rejected by a Party, or is canceled, not renewed or materially changed, a certificate for the substitute policy shall be submitted to the other Parties as early as possible before the commencement of the policy period for review and approval. Each Party shall annually supply the other Parties with proof of all required insurance in the form of a policy or certificate.

6.07 Required Provisions of Manager's Policies. Each of the Parties' policies, and any policies or policies procured hereunder, shall satisfy the following requirements:

(a) Manager shall be listed as an additional insured on a primary and non-contributory basis under general liability, auto and umbrella policies as respects operations performed for HMC Parties under this Agreement; and

(b) Each policy shall provide by endorsement that Manager is to be given notice ninety (90) days prior to every cancellation, non-renewal, or material change of such policy.

6.08 Deductibles. Each Party shall be solely responsible to satisfy any and all deductibles and self-insured retentions contained in its insurance coverages as well as any excluded loss or losses if the same are within such Party's liability under this Agreement. If any Party desire higher deductibles on policies other than workers compensation, it must first obtain the prior written consent of the other Parties, which consent may be withheld in a Party's sole discretion.

6.09 Substitute Policies. Each Party reserves the right at any time during the Term to give notice to the other Parties that a Party has determined that a policy or policies procured in furtherance of this Section 6 are unsatisfactory to such Party as to form or substance, or that a Party has determined that an insurance company which has issued any policy in furtherance of this Section 6 has become unsatisfactory. If a Party receives such a notice from the other Parties, it shall immediately obtain a new and substitute policy or policies and submit the same for approval.

6.10 No Relief from Liability; Interpretation. A Party's failure to secure and maintain the insurance required under this Agreement shall not relieve such Party of its liability for any losses intended to be insured thereby. These insurance provisions shall not be construed or interpreted so as to conflict with the indemnification obligations of Section 7.

SECTION 7

INDEMNIFICATION AND LIMITATION OF LIABILITY

7.01 Indemnification.

(a) Except as expressly provided in Sections 7.01(b) or (c), Manager shall defend, indemnify and hold harmless each HMC Party from and against all liabilities, obligations, claims, losses, expenses (including attorneys' fees) of every kind and nature whatsoever (including, but not limited to, actual or alleged violation of any Applicable Law, ordinance, regulation, order, other judicial or administrative decree or any common law duty), claim incurred by third-parties, (each, a "Liability" and collectively, "Liabilities"), arising in connection with or by reason of Manager's failure to perform its obligations under and/or in accordance with the terms of this Agreement and/or the negligent acts or omissions of Manager or those acting on Manager's behalf. Manager shall use reasonable best efforts to incorporate this indemnification obligation in all contracts and subcontracts entered into with suppliers of materials or services, and all labor organizations who furnish skilled and unskilled labor, or who may perform any such labor or services in connection with a contract or subcontract entered into under or in connection with the services or other items to be provided under this Agreement. The indemnification obligation under this Section 7.01(a) shall not be limited in any way by any limitation on the amount or type of damages, compensation, or benefits payable by or for Manager, any subcontractor, or any subcontractor of a subcontractor under worker's compensation acts, disability benefit acts, or other employee benefit acts. HMC Parties shall promptly notify Manager of all notices of claims and tender the defense of claims. The Parties agree to exercise all reasonable efforts to cooperate with one-another to the extent their respective interests may appear. Manager's indemnity obligation includes indemnification for all reasonable expenses, court costs and attorney fees, including those incident to appeals incurred by or imposed upon HMC Parties in connection with enforcement or defense of HMC Parties' right to indemnity hereinabove provided. In addition, Manager agrees that HMC Parties may employ any attorney (or attorneys) of their choice in a matter or to enforce or defend HMC Parties' right to the indemnity hereinabove provided. However, if HMC Parties engage their own legal counsel, and Manager has engaged or offered to engage legal counsel to defend HMC Parties in the matter, HMC Parties shall bear their own costs and expenses of their legal counsel, unless Manager's and HMC Parties positions in the matter are in conflict, in which case all reasonable costs and expenses of HMC Parties' legal counsel shall be borne by Manager.

(b) Manager need not indemnify and defend HMC Parties for Liability arising from the underground contamination of property, including environmental remediation or clean-up, except to the extent such contamination was caused or aggravated by Manager's management or by operation of the Hospital in violation of duties imposed on Manager under this Agreement. If property or groundwater contamination is discovered and was caused or aggravated by Manager' operation of the Hospital in violation of duties imposed under this Agreement, then the costs associated with such Liability shall be apportioned between Manager and the Person responsible for such costs (or HMC Parties, if no responsible other Person can be identified), if and to the extent it is possible to divide such costs, according to the degree of responsibility the law assigns to each. If the costs associated with such Liability cannot be apportioned in accordance with the immediately preceding sentence of this Section 7.01(b), Manager and HMC Parties shall equally share the costs. This Agreement does not alter any Liability HMC Parties may have prior to the Commencement Date for environmental remediation, environmental restoration, environmental repair or natural resources damages, under Applicable Laws. Manager need not indemnify or defend HMC Parties for Liability arising from construction project design or construction performed by third-parties contracting with HMC Parties. The Parties shall bear their own costs of defense and such Liability as the law assigns to each.

(c) With respect to this Section 7.01(c), the Parties shall have the right to defend their respective interests. The costs for such defense shall be included as part of the costs of Liability of the responsible Party pursuant to this Section 7.01(c).

(d) To the extent any Party requires any indemnity in any contract with a Person relative to the Hospital, such Party shall include each other Party as indemnified party in any such indemnification. Each Party shall give the other Parties prompt written notice of a claim and tender the defense when invoking any right of indemnification.

7.02 Limitation of Liability. Manager and HMC Parties acknowledge and agree that because of the unique nature of the undertakings contemplated by this Agreement, it is difficult or impossible to determine with precision the amount of damages that would or might be incurred by HMC Parties or Manager as a result of a breach of this Agreement. In no event, however, shall HMC Parties or Manager Parties be liable for or obligated in any manner, except to the extent of indemnification of claims of third-parties pursuant to Section 7.01, to pay incidental, special, punitive, consequential or indirect damages of any nature to the other Parties because of a breach of this Agreement (including acts of negligence, omissions or strict liability), warranty, delay or otherwise, arising out of the performance or nonperformance by HMC Parties or Manager of their obligations under this agreement, whether occurring during or subsequent to the performance of this Agreement. Notwithstanding the above, no Party shall be liable to the other Parties for matters that are prior to the Commencement Date or that were caused by material misrepresentations of fact.

7.03 Survival. This Section 7 shall survive the termination or expiration of this Agreement.

SECTION 8

EVENTS OF DEFAULT

8.01 Events of Default by Manager. The following shall constitute Events of Default by Manager (each, a "Manager Default") after the Commencement Date:

(a) To the extent such failures or refusals are not otherwise covered in this Section 8.01, persistent and repeated, failure or refusal of Manager to perform timely any material obligation under this Agreement, unless such failure or refusal is clearly recognized, justified and excused by the terms and conditions of this Agreement; or

(b) Misrepresentation of representations enumerated in Section 10.01;

(c) Failure of Manager to pay amounts owed to HMC Parties under this Agreement within thirty (30) days following the date they become due and owing; or

(d) Failure of Manager to meet any Conditions of Participation or other licensing conditions or requirements in a manner consistent with industry standards, unless such failure is clearly recognized, justified and excused by the terms and conditions of this Agreement; or

(e) Failure to comply with HMC Parties' inspection rights; or

(f) Failure to secure and maintain the insurance required under this Agreement; or

(g) The occurrence of an event that results in Insolvency.

8.02 Events of Default by HMC Parties. The following shall constitute Events of Default on the part of HMC Parties (each, an "HMC Parties Default") after the Commencement Date:

(a) To the extent such failures or refusals are not otherwise covered in this Section 8.02, persistent and repeated failure or refusal of HMC Parties to perform timely any material obligation under this Agreement, unless such failure or refusal is clearly recognized, justified and excused by the terms of and conditions of the Agreement; or

(b) Termination by HMC Parties of any authority given Manager under the terms of this Agreement, unless such termination is justified and excused by the circumstances resulting in such termination; or

(c) Misrepresentation of the representations enumerated in Section 10.02;

(d) Failure of HMC Parties to pay amounts owed to Manager under this Agreement within thirty (30) days following the time they become due and payable; or

(e) Failure to secure and maintain the insurance required (if any) under this Agreement; or

(f) Occurrence of an event that results in Insolvency.

8.03 Default Notices; Opportunity to Cure. This Agreement shall not be terminated for an Event of Default unless and until (i) the Party contemplating termination gives the offending Party written notice in reasonable detail specifying each Event of Default the offending Party is alleged to have committed or permitted ("Default Notice") and (ii) the offending Party shall has failed to cure such Event of Default within sixty (60) days (or such longer period as may reasonably be required to diligently effect such cure) following delivery of the Default Notice to the offending Party; provided, however, the foregoing cure period shall be reduced from sixty (60) days to such shorter period as may be required to avoid regulatory sanctions or other avoidable damages. Notwithstanding anything to the contrary contained herein, no Party shall be required to give a Default Notice in connection with the same issue more than twice during the Term, and any subsequent Event of Default involving the same issue shall entitle the non-defaulting Party to immediately exercise all available remedies including, but not limited to, termination.

SECTION 9

TERM AND TERMINATION

9.01 Term and Renewal.

(a) Unless sooner terminated in accordance with its terms and conditions, this Agreement shall have an initial term of seven (7) years from the Commencement Date (the "Initial Term").

(b) Not before the end of the fourth (4th) Billing Year and not after the end of the fifth (5th) Billing Year, HMC Parties shall give Manager written notice by certified mail of HMC

Parties' intention to terminate this Agreement at the end of the Initial Term. If HMC Parties fail to notify Manager as provided in this Section 9.01(b), this Agreement, at Manager's option, shall renew at the end of the Initial Term under the same terms and conditions for an additional term of three (3) years (the "First Renewal Term"). If HMC Parties shall notify Manager as provided herein, this Agreement shall expire effective as of the last day of the Initial Term.

(c) Not before the end of the seventh (7th) Billing Year and not after the end of the eighth (8th) Billing Year, HMC Parties shall give Manager written notice by certified mail of HMC Parties' intention to terminate this Agreement at the end of the First Renewal Term. If HMC Parties fail to notify Manager as provided in this Section 9.01(c), this Agreement, at Manager's option, shall renew at the end of the First Renewal Term under the same terms and conditions for an additional term of three (3) years (the "Second Renewal Term"). If HMC Parties shall notify Manager as provided herein, this Agreement shall expire effective as of the last day of the First Renewal Term.

(d) Not before the end of the tenth (10th) Billing Year and not after the end of the eleventh (11th) Billing Year, HMC Parties shall give Manager written notice by certified mail of HMC Parties' intention to terminate this Agreement at the end of the Second Renewal Term. If HMC Parties fail to notify Manager as provided in this Section 9.01(d), this Agreement, at Manager's option, shall renew at the end of the Second Renewal Term under the same terms and conditions for an additional term of three (3) years (the "Third Renewal Term"). If HMC Parties shall notify Manager as provided herein, this Agreement shall expire effective as of the last day of the Second Renewal Term.

9.02 Termination for Manager Default. If HMC Parties give Manager a Default Notice of the occurrence of Manager Default, and the Manager Default specified therein is not cured within the period set forth in Section 8.03, HMC Parties may terminate this Agreement.

9.03 Termination for HMC Parties Default. If Manager gives HMC Parties a Default Notice of the occurrence of an HMC Parties Default, and HMC Parties Default specified therein is not cured within the period set forth in Section 8.03(a), Manager may terminate this Agreement.

9.04 Termination for Uncontrollable Circumstances; Insolvency.

(a) If an Uncontrollable Circumstance shall occur after the Commencement Date relative to a material obligation of Manager or HMC Parties under this Agreement and such Uncontrollable Circumstance or the effect thereof prevents performance of such material obligation for a period of thirty (30) days, the Parties shall, during or after such thirty (30)-day period, meet to review the situation. If, despite the good faith efforts of the Parties to reach an agreement, no agreement is reached within a reasonable time considering the nature and extent of the Uncontrollable Circumstance, any Party may terminate this Agreement upon notice to the other Parties.

(b) In the event of an HMC Parties Default resulting from Insolvency, the Parties shall work together, in good faith and to the extent practicable, for the benefit of the local community in order to ensure an (i) orderly transition of the operations of the Hospital to a new owner and (ii) the continuity of management for the Hospital either under the terms and conditions of this Agreement or through a new management arrangement on terms mutually acceptable to Manager and the new owner.

transfer this Agreement or its right, title or interests or obligations therein, in whole or in part, in violation of Sections 11.01 and 11.02, each other Party may, in its sole discretion, terminate the Agreement. All rights, title and interest of the breaching Party will thereupon cease and terminate.

9.06 Remedies of Parties.

(a) If HMC Parties terminate this Agreement pursuant to Sections 9.02 or 9.05, HMC Parties shall have the right to seek all available legal and equitable remedies

(b) If Manager terminates this Agreement pursuant to Sections 9.03 or 9.05, Manager shall have the right to seek all available legal and equitable remedies; provided that if such termination shall occur during the first three (3) years of the Initial Term, Manager shall have the option to liquidate its damages by electing to receive payment of the Management Fee through the end of such thee (3) year period.

(c) In the event of a Manager Default, either of HMC Parties may, in its discretion, determine to perform any of Manager's obligations under this Agreement that Manager has failed to perform. HMC Parties may make available to Manager a notice of HMC Parties' intent to perform such obligations. Manager shall be obligated to reimburse HMC Parties for all costs HMC Parties incur in the performance of such obligations. HMC Parties' performance under this paragraph (c) shall not cure a Manager Default; provided that any cure period shall be tolled during the period any HMC Party is performing Manager's obligations.

(d) If any HMC Party has notified Manager of a Manager Default and HMC Parties determine, in their sole discretion, that the public safety is threatened by such Manager Default, HMC Parties may assume operation of the Hospital pending termination of this Agreement and direct Hospital Personnel, or contract with others, to take such actions as HMC Parties deem necessary or appropriate to protect the public safety. Any costs incurred by HMC Parties in such respect shall be paid by Manager.

9.07 Reconciliation of Payment. Within sixty (60) days following termination or expiration of this Agreement, the Parties shall reconcile all amounts then due and payable to each other under the terms of this Agreement. Upon reaching, as a result of such reconciliation, the total amount of the outstanding unpaid balance that the Parties owe each other, The Parties shall, within thirty (30) days thereafter, make the final payments in complete discharge of their payment obligations under this Agreement, except those obligations which survive the termination or expiration of this Agreement. Payment obligations under this Section 9.07 are subject to Sections 11.13 and 11.14.

9.08 Operations Transition; Transfer of Hospital Personnel.

(a) If either of HMC Parties or Manager terminates this Agreement, Manager shall, from the date of the notice of termination, make fully available its managers and employees performing services at the Hospital for at least one hundred eighty (180) days after the termination date pursuant to this Section 9.08 to continue to perform the Services. However, HMC Parties may determine that they require a lesser amount of Services in order to provide a smooth and orderly transition of the operations of the Hospital to HMC Parties. Manager shall fully cooperate with HMC Parties to effectuate such a transition.

(b) Notwithstanding the occurrence of an Event of Default and a resulting termination of this Agreement, HMC Parties shall compensate Manager for performing the Services as specified in Section 9.08(a), on a daily basis and in an amount equal to the daily allocated cost of the Services calculated on the basis of the Management Fee for the last full Billing Month immediately prior to the termination date; provided that such Management Fee shall be (i) calculated on the basis of a daily Management Fee and (ii) reduced on a *pro rata* basis to reflect the amount of Services being performed and the number of Manager's employees actually performing Services on a daily basis. Manager shall invoice HMC Parties for such Management Fee as calculated pursuant to this Section 9.08(b) within ten (10) days after the end of each month after the termination date, and HMC Parties shall pay to Manager the amount due and owing pursuant to this Section 9.08(b) within ten (10) days thereafter. The failure of HMC Parties to pay the amount due on a timely basis shall relieve Manager from any further obligations under this Section 9.08.

(c) Upon receipt of notice of termination, Manager shall, at the option of HMC Parties, cancel outstanding commitments for procurement of services, materials and supplies. In addition, Manager must exercise all reasonable diligence to cancel or divert to other activities its outstanding commitments for personal services, if HMC Parties, in their sole discretion so require. If, after serving notice of termination, HMC Parties determine that the reasons for termination are excusable and are not the fault of and beyond the control of Manager, HMC Parties may, in its sole discretion, authorize Manager to resume work.

(d) Manager recognizes and understands that the transition outlined in this Section 9.07 may well result in HMC Parties employing or attempting to employ some or all of the Hospital Personnel. Manager shall facilitate the transfer and employment of any Hospital Personnel who may desire to be employed by HMC Parties. Manager shall have no covenant not to compete or other restrictions that prohibit or impede HMC Parties' ability to hire Hospital Personnel; provided that HMC Parties shall not employ or attempt to employ the Chief Executive Officer of the Hospital.

(e) Upon the termination or expiration of this Agreement, Manager shall assign to HMC Parties its interest in all contracts entered into by Manager relative to the Hospital if requested by HMC Parties, if such contracts do not prohibit such assignment. HMC Parties' right to request assignment of certain contracts shall not be read as an obligation by HMC Parties to assume all or any of such contracts. HMC Parties shall, however, assume the payment and performance of all contracts assigned to it and shall pay any penalties and costs incurred by Manager with respect to the assignment of such contracts.

9.09 Survival. This Section 9 shall survive the termination or expiration of this Agreement.

9.10 Enforcement of Remedies. The remedies specifically set forth in this Agreement are not exclusive, and the Parties shall be free to pursue any other remedies available at law or in equity. Any Party may seek judicial enforcement of any remedy provided herein and any amounts payable hereunder.

SECTION 10

REPRESENTATIONS

10.01 Representations of HMC Parties. Subject to the disclosures in Exhibit 10.01, HMC Parties hereby represent to Manager that:

(a) HMC is a duly organized and existing Delaware corporation and is authorized to conduct business in Missouri and Oklahoma, and CAH11 is a duly organized and existing Delaware limited liability company and is authorized to conduct business in North Carolina;

(b) HMC Parties have the power, authority and legal right to enter into and perform this Agreement, and the execution, delivery and performance of this Agreement (i) has been duly authorized by the Final Confirmation Order and does not require any other approvals or consents by any other Person, (ii) will not violate any judgment, order, law or regulation applicable to HMC Parties or the Hospital or any provisions of HMC Parties' articles of incorporation or formation and By-Laws, and (iii) do not constitute a default under, or result in the creation of, any lien, charge, encumbrance or security interest upon any assets of HMC Parties under any agreement or instrument to which HMC Parties are a party or by which HMC Parties or their assets may be bound or affected;

(c) This Agreement has been duly entered into by HMC Parties and constitutes a legal, valid and binding obligation of HMC Parties, enforceable in accordance with its terms, subject to (i) the applicable bankruptcy, reorganization, moratorium or similar Applicable Laws affecting enforcement of creditors' rights or remedies generally, (ii) general equitable principles concerning remedies, and (iii) limitations on the enforceability of rights by Applicable Laws;

(d) To the best of HMC Parties' information and belief and without independent investigation, there is no action, suit or proceeding, at law or in equity, before or by any court or governmental authority, pending or threatened against HMC Parties, wherein an unfavorable decision, ruling or finding would materially adversely affect the performance by HMC Parties of its obligations hereunder, or which, in any way, would adversely affect the validity or enforceability of this Agreement, or any other agreement or instrument entered into by HMC Parties in connection with the transaction contemplated hereby; and

(e) There has been no material adverse change in HMC Parties' financial condition which would impair HMC Parties' ability to perform their obligations under this Agreement.

10.02 Representations of Manager. Subject to the disclosures in Exhibit 10.02, Manager hereby represents to HMC Parties that:

(a) Manager is a duly organized and existing West Virginia limited liability company and is, or within twenty (20) days after the Commencement Date will be, qualified to do business wherever necessary to carry on the business and operations of the Hospital as contemplated by this Agreement.

(b) Manager has the power, authority and legal right to enter into and perform its obligations set forth in this Agreement, and the execution, delivery and performance hereof, (i) have been duly authorized, (ii) do not require the approval of any governmental office or body, (iii) will not violate any judgment, order, law or regulation applicable to Manager or any provisions of Manager's articles of formation and bylaws, and (iv) do not constitute a default under or result in the creation of, any lien, charge, encumbrance or security interest upon any assets of Manager under any agreement or instrument to which Manager is a party or by which Manager or its assets may be bound or affected.

(c) This Agreement has been duly entered into and delivered and constitutes a legal, valid and binding obligation of Manager, fully enforceable in accordance with its terms, subject to (i) the applicable bankruptcy, reorganization, moratorium or similar Applicable Laws affecting

enforcement of creditors' rights or remedies generally, (ii) general equitable principles concerning remedies and (iii) limitations on the enforceability of rights by Applicable Laws;

(d) To the best of Manager's information and belief and without independent investigation, there is no action, suit or proceeding, at law or in equity, before or by any court or governmental authority, pending or, to the best of Manager's knowledge, threatened against Manager, wherein an unfavorable decision, ruling or finding would materially adversely affect the performance by Manager of its obligations hereunder, or which, in any way, would adversely affect the validity or enforceability of this Agreement, or any other agreement or instrument entered into by Manager in connection with the transaction contemplated hereby; and

(e) There has been no material adverse change in Manager's financial condition which would impair Manager's ability to perform its obligations under this Agreement.

10.03 Materiality of Representations. The representations enumerated in Sections 10.01 and 10.02 are material for purposes of this Agreement and misrepresentations are grounds for termination of this Agreement.

SECTION 11

MISCELLANEOUS

11.01 Assignment by HMC Parties. HMC Parties reserve the right to transfer in a Change of Control transaction or otherwise assign, their rights and obligations under this Agreement to another Person, provided that HMC Parties and the Person involved in the transfer or assignment shall agree, in a written instrument (the form and substance of which shall be subject to Manager's approval), to remain liable for all the duties and obligations of HMC Parties under this Agreement. HMC Parties and such Person will provide Manager with prior notice of such a transfer or assignment.

11.02 Assignment by Manager. Manager will not assign or transfer the Agreement or its right, title or interests or obligations therein, in whole or in part, without in each instance HMC Parties' advance written approval, except that Manager may assign its interest without such consent to any successor or Affiliate, provided that Manager shall remain liable for all obligations under this Agreement. It is acknowledged and agreed between the Parties that this Section 11.02 shall not be construed or interpreted to restrict Manager's ability to employ subcontractors in connection with performance of portions of its obligations hereunder.

11.03 Local Involvement. To the extent not inconsistent with its obligations under this Agreement, Manager shall use its best efforts consistent with Applicable Laws to maximize involvement of a diversified group of local firms ("Local Providers") that have capabilities to provide and implement a portion of the Services ("Local Services"). Manager shall exercise the appropriate supervision of and control over the Local Providers so that the Local Providers will perform the Local Services in a manner which will not damage Manager and/or HMC Parties and be responsible for all aspects of performance of the Local Providers in performing the Local Services.

11.04 Further Assurances. Each Party agrees to execute and deliver any instruments and to perform any acts that may be necessary or reasonably requested in order to give full effect to this Agreement. HMC Parties shall execute such further instruments and documents and take such action as may be reasonably requested by Manager and not inconsistent with the provisions of this Agreement and not involving the assumption of obligations other than those provided for in this Agreement to carry out the intent of this Agreement.

11.05 Notices and Authorized Representatives.

(a) All notices, consents, approvals or communications required or permitted hereunder shall be in writing and be made available to a Party addressed as follows:

To Manager:	Rural Community Hospitals of America 1100 Main Suite 2350 City Center Square Kansas City, Missouri 64105 Attention: Authorized Representative
With a copy to:	Rural Community Hospitals of America %_____ _____ _____ Attention: Steve White
To HMC Parties:	HMC/CAH Consolidated, Inc. 1100 Main Suite 2350 City Center Square Kansas City, Missouri 64105 Attention: Authorized Representative
With a copy to:	Husch Blackwell LLP 4801 Main, Suite 1000 Kansas City, MO 64112 Attention: Chris Kirley

Changes in the respective addresses to which such notices may be directed may be made from time to time by any Party by written notice to the other Parties.

(b) For purposes of this Agreement, the Parties' Authorized Representative(s) are as follows:

For Manager: Larry Arthur

For HMC Parties: _____

Any Party may change its Authorized Representatives at any time by written notice to the other Parties.

11.06 Waiver. The waiver by any Party of a default or a breach of any provision of this Agreement by another Party shall not operate or be construed to operate as a waiver for any other Party or of any subsequent default or breach. The making or the acceptance of a payment by any Party with knowledge of the existence of a default or breach shall not operate or be construed to operate as a waiver of such default or breach or any subsequent default or breach.

11.07 Entire Agreement; Modifications and Amendments. The provisions of this Agreement, together with the Exhibits referred to and attached hereto, shall constitute the entire

agreement between the Parties for the operation, management and maintenance of the Hospital and shall supersede any negotiation, proposal or agreement, written or oral, prior to the Commencement Date, there being no agreements or understandings other than those written or specified in this Agreement. In the event of a conflict or inconsistency between or among the Exhibits and this Agreement, it is acknowledged and agreed that this Agreement shall control over the Exhibits. Unless otherwise specifically recognized herein, this Agreement shall not be modified or amended except by written agreement duly entered into and executed by the Parties with the same formality as this Agreement.

11.08 Headings. Captions and headings and this Agreement are for ease of reference only and do not constitute a part of this Agreement.

11.09 Governing Law. This Agreement and any questions concerning its validity, construction or performance shall be governed exclusively by the Applicable Laws of the State, without respect to conflicts of law principals and irrespective of the place of execution or of the order in which the signatures of the Parties are affixed or of the place or places of performance.

11.10 Consents to Jurisdiction. The Parties hereby irrevocably consent to the personal and subject matter jurisdiction of any court of competent jurisdiction within the State in connection with any action or proceeding arising out of or relating to the Agreement or any document or instrument delivered with respect to any of the obligations hereunder, and waive personal service of any process in connection with any such action or proceeding and agrees that the service thereof may be made by hand delivery or by certified or registered mail directed to the other Parties and their counsel at the addresses set forth in this Agreement.

11.11 Counterparts. This Agreement may be executed in more than one counterpart, each of which shall be deemed to be an original.

11.12 Severability. In the event that any provision of this Agreement shall, for any reason, be determined to be invalid, illegal, or unenforceable in any respect, the Parties hereto shall negotiate in good faith and agree to such amendments, modifications, or supplements of or to this Agreement or such other appropriate actions as shall, to the maximum extent practicable in light of such determination, implement and give effect to the intentions of the Parties as reflected herein, and the other provisions of this Agreement shall, as so amended, modified, supplemented, or otherwise affected by such action, remain in full force and effect.

11.13 Interest on Overdue Payments. All payments to be made under this Agreement by any Party outstanding after the applicable due date shall be compounded annually at rate eight (8%) percent per annum.

11.14 Payment Disputes. If any Party shall dispute an amount owing to another Party, such Party shall (a) give notice to such other Party of such disputed amount together with sufficient information to allow such other Party to understand the nature of the dispute delivered on or before the due date of the amount disputed, and (b) pay all undisputed amounts on the due date. Interest at the rate specified in Section 11.13 shall accrue from the original due date on disputed amounts, or the portions thereof, to the Party which is ultimately determined to be entitled to such disputed amount, or any portions of such disputed amounts.

11.15 Liability of Officers and Employees. No member of the governing bodies of any Party nor any director, manager, officer, agent, or employee of any Party shall be charged personally by the other or held contractually liable thereto under any term or provision of this

Agreement, because of a Party's execution hereof or because of any breach or alleged breach thereof; provided that all Persons remain responsible for any of their own criminal or civil tort actions.

11.16 No Pledge of Credit. No Party shall pledge any other Party's credit or make any of them a guarantor of payment or surety for any contract, debt, obligation, judgment, lien or any form of indebtedness.

11.17 Third-Party Beneficiary. This Agreement is intended to be solely for the benefit of the Parties and their successors and permitted assigns and is not intended to and shall not infer any rights or benefits on any third-party not a signatory to this Agreement.

11.18 Intellectual Property Rights. HMC Parties hereby grant to Manager the irrevocable right to use all processes, know-how, technology, computer software, and other intellectual property (the "Intellectual Property") owned by HMC Parties or its Affiliates on the Commencement Date and used, developed, upgraded, enhanced or otherwise improved by HMC Parties or Manager or its Affiliates in connection with the performance of their obligations pursuant to all Applicable Laws and this Agreement, both during the Term and after its expiration or termination; provided that Manager may not sell, license or formally authorize any other Person to use the Intellectual Property, but Manager and its employees and representatives may discuss, publish or otherwise freely and publicly communicate information concerning the Intellectual Property. Any license owned by HMC Parties shall not be transferable by Manager. Manager acknowledges and agrees that the Intellectual Property owned by HMC Parties or its Affiliates on the Commencement Date and used, developed, upgraded, enhanced or otherwise improved by HMC Parties or Manager in connection with the performance of their obligations pursuant to this Agreement shall remain the property of HMC Parties or its Affiliates both during the Term and after its expiration or termination.

11.19 Patented Invention Rights. Each Party retains exclusive rights to all its patented inventions and copyrighted materials, developed by any Party in connection with the performance of its obligations pursuant to this Agreement.

[The remainder of this page intentionally left blank]

SIGNATURE PAGE TO MANAGEMENT AGREEMENT

FOR

LAUDERDALE COMMUNITY HOSPITAL

In Witness Whereof, the Parties hereto have caused this Agreement to be executed by their duly authorized officers as of 1-17, 2013.

HMC/CAH PARTIES:

HMC/CAH CONSOLIDATED, INC.,

By: _____
Name: Larry Addax
Title: President/CEO

ATTESTED BY: _____
Name: Dennis Davis
Title: Secretary

CAH ACQUISITION COMPANY 11, LLC

By: _____
Name: Larry Addax
Title: President

ATTESTED BY: _____
Name: Dennis Davis
Title: Secretary

MANAGER:

RURAL COMMUNITY HOSPITAL OF AMERICA, LLC

By: _____
Name: PAUL L. NUSBAUM
Title: Manager

Exhibit 5.03

QUALITY IMPROVEMENT MEASURES OF INCENTIVE FEE

The following quality improvement measures are mutually agreed to by the Parties as of the Commencement Date. Such measures shall act as a trigger for the calculation of the Incentive Fee based upon the financial performance measures to be agreed upon by the Parties within 180 days after the Commencement Date.

Introduction

The Parties agree that they we must predicate the right of the Manger to receive an Incentive Fee based upon the improvement of the clinical performance of the Hospital. The logical way in which to do this is to incorporate a component of the Centers for Medicare and Medicaid Services (CMS) Core Measures as specifically applied to critical access hospitals. A Core Measure is one that utilizes the results of evidence based medicine research. This principle implies that it is reasonable to expect that every patient with a given diagnosis will receive the baseline or core care that has been established through such research.

Core Measures represent high volume, high cost diagnoses associated with an increased rate of morbidity as determined by CMS. This program, now known as the Hospital Inpatient Quality Reporting Program (IQR), which now includes over thirty measures, is intended to accomplish the following:

* Improve patient care;
* Assure the local community that the hospital is providing high quality care;
* Inform the public; and
* Provide management/governance with the means by which the clinical performance can be measured.

In accordance with the importance of the above, the Parties believe that the attainment of an acceptable performance rating as measured against the national and state Core Measures benchmarks should be the threshold requirement or trigger for even being considered for incentive compensation based on the provision of management services and financial performance. Only after successfully meeting the Core Measures component of the incentive program would the Manager be considered eligible for incentive compensation, based on the more traditional measures of financial performance.

Approach

The current Core Measures for critical access hospitals include inpatient process of care measures that reflect recommended treatments for:

* Acute myocardial infarctions ("AMI");
* Heart failure;
* Pneumonia;
* Surgical care improvement

In accordance with the above, the Parties agree that the Hospitals be measured against the average for all reporting hospitals in the United State and the state in which the facility is located

in the following manner:

1) Treatment for AMI Measures:

* Average number of minutes before outpatients with chest pain, possible heart attack or a need for specialized care were appropriately transferred to another hospital;
* Number/percentage of heart attack patients given aspirin at discharge;
* Average number of minutes before outpatients experiencing chest pain or a possible heart attack received an EKG;
* The number/percentage of outpatients experiencing chest pain or possible heart attack who received drugs within thirty (30) minutes of arrival to break up possible blood clots;
* Outpatients experiencing chest pain or possible heart attack who received aspirin within twenty-four (24) hours of arrival; and
* Heart attack patients given fibrinolytic medication within thirty (30) minute of arrival.

2) Heart Failure Measures:

* Number/percentage of patients presenting with heart failure given discharge instructions
* Number/percentage of patients presenting with heart failure given an evaluation of Left Ventricular Systolic ("LVS") function; and
* Number/percentage of patients presenting with heart failure given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction ("LVSD").

3) Pneumonia Measures:

* Number/percentage of patients presenting with pneumonia whose initial blood culture was performed prior to the administration of the first hospital dose of antibiotics; and
* Number/percentage of patients presenting with pneumonia who were given the most appropriate initial antibiotic(s).

4) Surgical Care Improvement Processes Measures:

* Assuring that all applicable patients receive the /recommended prescribed antibiotics at the correct time prior to surgery;
* Assuring that the administration of prescribed antibiotics that are administered in conjunction with surgical procedures is stopped at the correct time after completion of the surgery;
* Maintaining surgical patients' temperature and blood glucose (sugar levels at normal levels;
* Removing patient catheters in a timely manner after surgery that are used to drain the patient's bladder during the surgical procedure;
* For cardiac patients, assuring that certain prescription drugs, including drugs used to control heart rhythms and blood pressure, are continuously administered during the period immediately before, during and after surgery; and
* Administering drugs that prevent blood clots and using other methods such as special stockings in order to increase circulation in the legs.

Accreditation Standards

Critical access hospitals are required to collect data internally on a minimum of four Core Measure sets or a combination of Core Measure sets and other quality measures that are generally referred to as 'non-core' measures although they are not required, at this time, to report this data to accrediting organizations. Although the foregoing list of Core Measures is not exhaustive, their collective importance to maintaining a high level of quality is obvious and it is therefore the Parties agree that they be used. Other Core Measures may become available at which time the Parties may agree to add to or replace those set forth above.

Statistical Relevance

Although the Core Measures previously discussed address conditions commonly treated by rural and critical access hospitals, such hospitals, in many instances, simply do not treat a sufficient number of patients in a particular category to meaningfully calculate and assess performance on a quarterly basis (e.g. CMS requires that there be a minimum of twenty-five (25) qualifying cases before reporting). However, the underlying assumption is that as a particular data base is expanded to a full four quarters of data for each measure, the number of cases will increase , thereby increasing the reliability and consistency of the results.

Additional Quality Measures

In addition to the Core Measures, additional consideration should be given to patient satisfaction, regulatory compliance issues (e.g. compliance with EMTALA requirements, compliance with annual OIG Work Plan requirements and annual compliance education).

FIRST AMENDMENT TO

MANAGEMENT AGREEMENT

(LAUDERDALE COMMUNITY HOSPITAL, Ripley, TN)

THIS AMENDMENT TO MANAGEMENT AGREEMENT ("Amendment") is made and entered into effective as of the last date written below by and among HMC/CAH CONSOLIDATED, INC., a Delaware corporation ("HMC"), and CAH ACQUISITION COMPANY 11, LLC, a Delaware Limited Liability Company ("CAH11") , and RURAL COMMUNITY HOSPITALS OF AMERICA, LLC, a West Virginia limited liability company (the "Manager"). HMC and CAH11 are referred to individually as "HMC Party" and collectively as "HMC Parties". HMC Parties and Manager are referred to individually as a "Party" and collectively as the "Parties."

PREMISES

A. The Parties entered into a certain Management Agreement dated as of January 17, 2013 (the "Agreement").

B. Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Agreement.

C. The Parties mutually desire to amend the Agreement as hereinafter set forth.

NOW, THEREFORE, for good and valuable considerations, the receipt and sufficiency of which are hereby acknowledged, it is hereby agreed as follows:

1. Recitals. The foregoing recitals and introductory paragraphs are incorporated herein as if fully here set forth.

2. Amendments to Agreement.

(a) The Agreement is hereby amended and supplemented by deleting Section 1.03(d) thereof in its entirety and replacing it with the following:

(d) "Commencement Date" means December 20, 2013.

(b) The Agreement is hereby amended and supplemented by deleting Section 9.01(a) thereof in its entirety and replacing it with the following:

(a) Unless sooner terminated in accordance with its terms and conditions, this Agreement shall have an initial term ten (10) years from the Commencement Date (the "Initial Term").

3. Ratification. Except as specifically set forth in this Amendment, all provisions of the Agreement shall be unmodified and shall remain in full force and effect. The Agreement, as amended by this Amendment, is hereby ratified and confirmed.

4. Counterparts and Facsimile. This Amendment may be executed in multiple counterparts, each of which, when taken together shall constitute fully executed originals.

Signature and transmission by facsimile transmission shall be deemed effective as if original signatures on the original documents.

In Witness Whereof, the Parties hereto have caused this Agreement to be executed by their duly authorized officers as of December ___, 2013.

HMC/CAH PARTIES:

HMC/CAH CONSOLIDATED, INC.

By: _____
Gordon Lansford, Vice President

CAH ACQUISITION COMPANY 11, LLC

By: _____
Gordon Lansford, Vice President

MANAGER:

RURAL COMMUNITY HOSPITALS OF AMERICA, LLC

By: _____
Paul Nusbaum, Manager

Description of Management Entity's Experience:

Rural Community Hospitals of America, LLC ("RCHA") has managed Lauderdale Community Hospital from January 17, 2013 through the present and will continue to provide management services through the CON process, the construction of the new facility, and after the new hospital is completed. The initial term of the management contract runs through December 2023. RCHA currently manages several rural hospitals, including 10 Critical Access Hospitals and two PPS hospitals throughout several states. RCHA is a West Virginia LLC that 100% owned by Sun Finance, Inc.

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 4

Section A, Item 6

Deed of Trust

WARRANTY DEED

THIS WARRANTY DEED, made and entered into this 31st day of March, 2010, by and between BAPTIST MEMORIAL HOSPITAL–LAUDERDALE, INC., a not-for-profit Tennessee corporation ("Grantor") and CAH ACQUISITION COMPANY 11 LLC, a Delaware limited liability company ("Grantee"),

WITNESSETH:

THAT FOR AND IN CONSIDERATION of the sum of One and no/100 Dollars ($1.00), the receipt and sufficiency of which is hereby acknowledged, Grantor has bargained and sold and does hereby bargain, sell, convey and confirm unto Grantee the following described real estate, together with all improvements thereon, lying, situated and being within the 2nd Civil District of Lauderdale County, Tennessee, and more particularly described as follows, to-wit:

Being part of the L. M. Kirkpatrick, Jr., properly located at Ripley, Lauderdale County, Tennessee, more particularly described as follows:

Beginning at a concrete monument at the intersection of the east right-of-way line of U.S. Highway 51 By-Pass with the south right-of-way line of Asbury Road; thence N 44° 42' E along the south line of Asbury Road 235 feet to an offset in said south line; thence N 35° 52' W along said offset 16.66 feet to a point 30 feet southeastwardly from the center line of Asbury Road; thence northeastwardly along the south line of Asbury Road by a curve to the right having a radius of 1141.56 feet an arc distance of 221.85 feet to a point of compound curve; thence continuing along said south line by a curve to the right having a radius of 1562.25 feet an arc distance of 289.97 feet to a point of compound curve; thence continuing along said south line by a curve to the right having a radius of 717.67 feet an arc distance of 99.43 feet to a point of compound curve; thence continuing along said south line by a curve to the right having a radius of 7130.11 feet an arc distance of 330.81 feet to a point of tangency; thence N 88° 50' E continuing along the south line of Asbury Road 564.89 feet to a point; thence S 01° 10' E, 970 feet to a point; thence S 89° 22' 51" W, 1793.75 feet to a point in the east right-of-way line of U.S. Highway 51By-Pass; thence N 14° 42' E along said east line 600 feet to the point of beginning.

BEING the land held by Grantor by virtue of grantor by virtue of deed recorded in Book 202, Page 274, Register's Office of Lauderdale County, Tennessee

TO HAVE AND TO HOLD the aforesaid real estate, together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto Grantee, its heirs and assigns, in fee simple forever. Grantor does hereby covenant with Grantee that Grantor is lawfully seized in fee of the aforesaid real estate; that Grantor has a good right to sell and convey the same; that the same is unencumbered except:

(1) Any taxes not yet due but constituting a lien, which are assumed by Grantee;

(2) Any subdivision restrictions, easements, and building setback lines; and

(FOR RECORDING DATA ONLY)

Property Address:

326 Asbury Avenue, Ripley, Tennessee 38063

Property Owner:

CAH Acquisition Company 11, LLC

Ward ___Block ____Parcel ____

Mail tax bills to: (Person or Agency responsible for payment of taxes)

HMC/CAH Consolidated, Inc.
1100 Main Street, Suite 2350
Kansas City, MO 64105
Attention: Gary Clifton, CFO

This instrument return to:

Barbara S. Gardner, Atty.
Chicago Title Insurance Company
6060 Poplar Avenue, Suite LL-37
Memphis, TN 38119
CTIC#_____

I, or we, hereby swear or affirm that to the best of affiant's knowledge, information, and belief, the actual consideration for this transfer or value of the property transferred, whichever is greater is $3,500,000 which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

Daniel C. Hogan
Affiant

Subscribed and sworn to before me this 31st day of March, 2010.

Cathy Tenpenny
Notary Public

My Commission Expires:
6-29-2011

CATHY TENPENNY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

I hereby swear or affirm that to the best of affiant's knowledge, information, and belief, the actual consideration for this transfer is $3,500,000.

David C Morgan
Affiant

CATHY TENPENNY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

Subscribed and sworn to before me this 31st day of March, 2010.

Cathy Tenpenny
Notary Public My Commission Expires: 6-29-2011

Property Owner: CAH Acquisition Company 11, LLC

Property known as: 326 Asbury Avenue, Ripley, Tennessee 38063.

Mail Tax Bills To: HMC/CAH Consolidated, Inc.
1100 Main Street, Suite 2350
Kansas City, MO 64105
Attention: Gary Clifton, CFO

(3) The easements of record at Book 275 at page 312, Book 275 at page 314, Book 275 at page 316, Book 275 at page 318, and Book 34 at page 505 in the Register's Office for Lauderdale County, Tennessee.

And that the title and quiet possession Grantor warrants and will forever defend against the lawful claims of all persons. Any reference to recorded instruments is reference to the Register's Office in said County.

IN TESTIMONY WHEREOF, Grantor made and has executed this Warranty Deed on the date and year first above written.

Attest:

Secretary

BAPTIST MEMORIAL HOSPITAL–LAUDERDALE, INC.

By: David C. Hogan

Vice President

STATE OF TENNESSEE

COUNTY OF SHELBY

BEFORE ME, Cathy Tenpenny, a Notary Public of the State and County aforementioned, personally appeared DAVID C. HOGAN, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the Vice President of Baptist Memorial Hospital–Lauderdale, Inc., a not-for-profit Tennessee corporation and as such Vice President executed the foregoing instrument for the purpose therein contained, and acknowledged the instrument to be the free act and deed of Baptist Memorial Hospital–Lauderdale, Inc.

WITNESS my hand and seal, this 31st day of March, 2010.

Cathy Tenpenny

Notary Public

CATHY TENPENNY STATE OF TENNESSEE NOTARY PUBLIC SHELBY COUNTY

My Commission Expires: 6-29-2011

Personally known: ✓ or Produced Identification: ____Type of Identification Produced: _____
Driver's License _____ Other: _____

This instrument prepared by:
Dennis Davis, Attorney at law
1100 Main Street, Suite 2350
Kansas City, Missouri 64105

QUITCLAIM DEED

KNOW ALL MEN BY THESE PRESENTS, that BAPTIST MEMORIAL HOSPITAL–LAUDERDALE, INC., a not-for-profit Tennessee corporation, the party of the first part, for and in consideration of the sum of One and no/100 Dollars ($1.00), the receipt and sufficiency of which is hereby acknowledged, does hereby bargain, sell, release, remise, quit claim and convey unto CAH ACQUISITION COMPANY 11 LLC, a Delaware limited liability company, the party of the second part, all right, title and interest of the party of the first part in and to the following described real estate, together with all improvements thereon, lying, situated and being within the 2nd Civil District of Lauderdale County, Tennessee, and more particularly described as follows, to-wit:

Beginning at an iron pin set in the east margin of Highway 51, (130 feet from centerline), said point being the northeast corner of a tract in the name of Farm Credit Services of Mid America, as recorded in Deed Book 425 Page 275 in the Register's Office of Lauderdale County, Tennessee; runs thence with the east margin of Highway 51, the following calls: north 21 degrees 17 minutes 32 seconds east 599.55 feet to a right of way monument found; thence with the east margin of Highway 51 north 51 degrees 17 minutes 32 seconds east 235.00 feet to an iron pin set; thence north 29 degrees 16 minutes 28 seconds west 12.86 feet to an iron pin set in the south margin of Asbury Road, (30 feet from centerline); runs thence with the south margin of Asbury Road, the following calls: along a curve to the right, having a radius of 1434.58 feet, a chord direction of north 70 degrees 14 minutes 33 seconds east, a chord length of 325.87 feet, and an arc length of 326.57 feet to a point; thence along a curve to the right, having a radius of 970.00 feet, a chord direction of north 84 degrees 39 minutes 38 seconds east, a chord length of 266.52 feet, and an arc length of 267.37 feet to a point; thence along a curve to the right, having a radius of 6903.27 feet, a chord direction of south 86 degrees 00 minutes 30 seconds east, a chord length of 345.65 feet, and an arc length of 345.69 feet to a point; thence south 84 degrees 34 minutes 26 seconds east 561.72 feet to a point, being north 05 degrees 11 minutes 31 seconds east 1.75 feet from a right of way monument found, and being the northwest corner of a tract in the name of Catherine Kirkpatrick Dean, as recorded in Deed Book 556 Page 801; runs thence with the west line of said Dean, and then with the west line of Lots 4, 5, 6, 7, and 8 of said Kirkpatrick Subdivision, as recorded in Plat Book 1, Page 69, south 05 degrees 11 minutes 31 seconds west 980.25 feet to an iron pin set, being an interior corner of said Lot 8; runs thence with Lot 8, 14, 15, 21, and 22 of said Kirkpatrick Subdivision, then with the north line of Lots 64, 63, 62, 61, and 60 of Willow Creek Estates, as recorded in Plat Book 1 Page 83, and with the north line of said Farm Credit Services of Mid America, north 83 degrees 32 minutes 41 seconds west 1793.54 feet to the point of beginning.

Book 202 Pg 274

M94 P 27.08

Annie Laura Jennings, Register
Lauderdale County Tennessee

Rec #:	147848	Instrument #:	158331
Rec'd:	15.00		Recorded
State:	0.00		4/9/2010 at 9:52 AM
Clerk:	0.00		in Record Book
EDP:	2.00		612
Total:	17.00		Pgs 267-269

IN TESTIMONY WHEREOF, the party of the first part has executed this Quitclaim Deed on this 31st day of March, 2010.

Attest:

Secretary

BAPTIST MEMORIAL HOSPITAL–LAUDERDALE, INC.

By: David C Hogan
Vice President

STATE OF TENNESSEE

COUNTY OF SHELBY

BEFORE ME, Cathy Tenpenny, a Notary Public of the State and County aforementioned, personally appeared David C. Hogan, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the Vice President of Baptist Memorial Hospital–Lauderdale, Inc., a not-for-profit Tennessee corporation, and as such Vice President executed the foregoing instrument for the purpose therein contained, and acknowledged the instrument to be the free act and deed of Baptist Memorial Hospital–Lauderdale, Inc.

WITNESS my hand and seal, this 31st day of March, 2010.

CATHY TENPENNY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

Cathy Tenpenny
Notary Public

My Commission Expires: 6-29-2011

Personally known: ✓ or Produced Identification: ____Type of Identification Produced: ____
Driver's License ____ Other: ____

I [redacted]

[redacted]
Affiant

I hereby swear or affirm that to the best of affiant's knowledge, information, and belief, the actual consideration for this transfer is None.

Affiant

Subscribed and sworn to before me this 31 day of March, 2010.

Notary Public

My Commission Expires:

CAROL R. BATEMAN
STATE OF TENNESSEE
NOTARY PUBLIC
COUNTY OF SHELBY

MY COMMISSION EXPIRES: APRIL 17, 2013

Property Owner: CAH Acquisition Company 11, LLC

Property known as: 326 Asbury Avenue, Ripley, Tennessee 38063.

Mail Tax Bills To: HMC/CAH Consolidated, Inc.
1100 Main Street, Suite 2350
Kansas City, MO 64105
Attention: Gary Clifton, CFO

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 5

Section A, Item 13

Existing MCO's and BHO's with which we have Agreements

Attachment 5
Section A, Item 13
Existing MCOs and BHOs with which we have agreements

As an existing provider of healthcare services, LCH has in place contractual and working relationships with existing healthcare providers within its service area. The following are existing agreements:

Amerigroup Community Care	Jackson-Madison County General Hospital
Arkansas Northeastern College	Lauderdale County Ambulance Authority
Baptist College of Health Sciences	Le Bonheur Children's Hospital Comprehensive Regional Pediatric Center
Baptist Health Services Group of the Mid-South Inc.	Le Bonheur Children's Medical Center
Baptist Memorial Hospital-Tipton	MultiPlan, Inc
BlueCross BlueShield of Tennessee	Prime Health Services, Inc.
CIGNA HealthCare of Tennessee, Inc	Tennessee College of Applied Technology-Ripley
Cigna-HealthSpring	Tennessee Hospital Association
Community Health Alliance	UnitedHealthcare of Tennessee, Inc
Concorde Career College	University of Memphis Loewenberg School of Nursing
DNV Healthcare, Inc	US Department of Health and Human Services
Dyersburg State Community College	Vanderbilt University Medical Center
Florida Agency for Healthcare Administration	Windsor Health Plan, Inc
Jackson State Community College	

BlueCare	PHCS
BluePreferred	Mail Handlers Benefit Plan
Blue Select	Correctional Medical Services
Blue Cross 65	Windsor Extra
Cover TN	Blue Advantage Plus HMO
Access TN	Humana Gold Plus Medicare HMO
Cover Kids	Medicare Advantra Freedom PFFS
AARP Health Options	Unison Medicare Advantage
Aetna PPO	Champus/Tricare
Coventry Healthcare	United Health Care Community Plan
GEHA	United Healthcare
Humana	United Healthcare Medicare HMO
Ironworkers #167	TennCare Select
Mutual of Omaha	

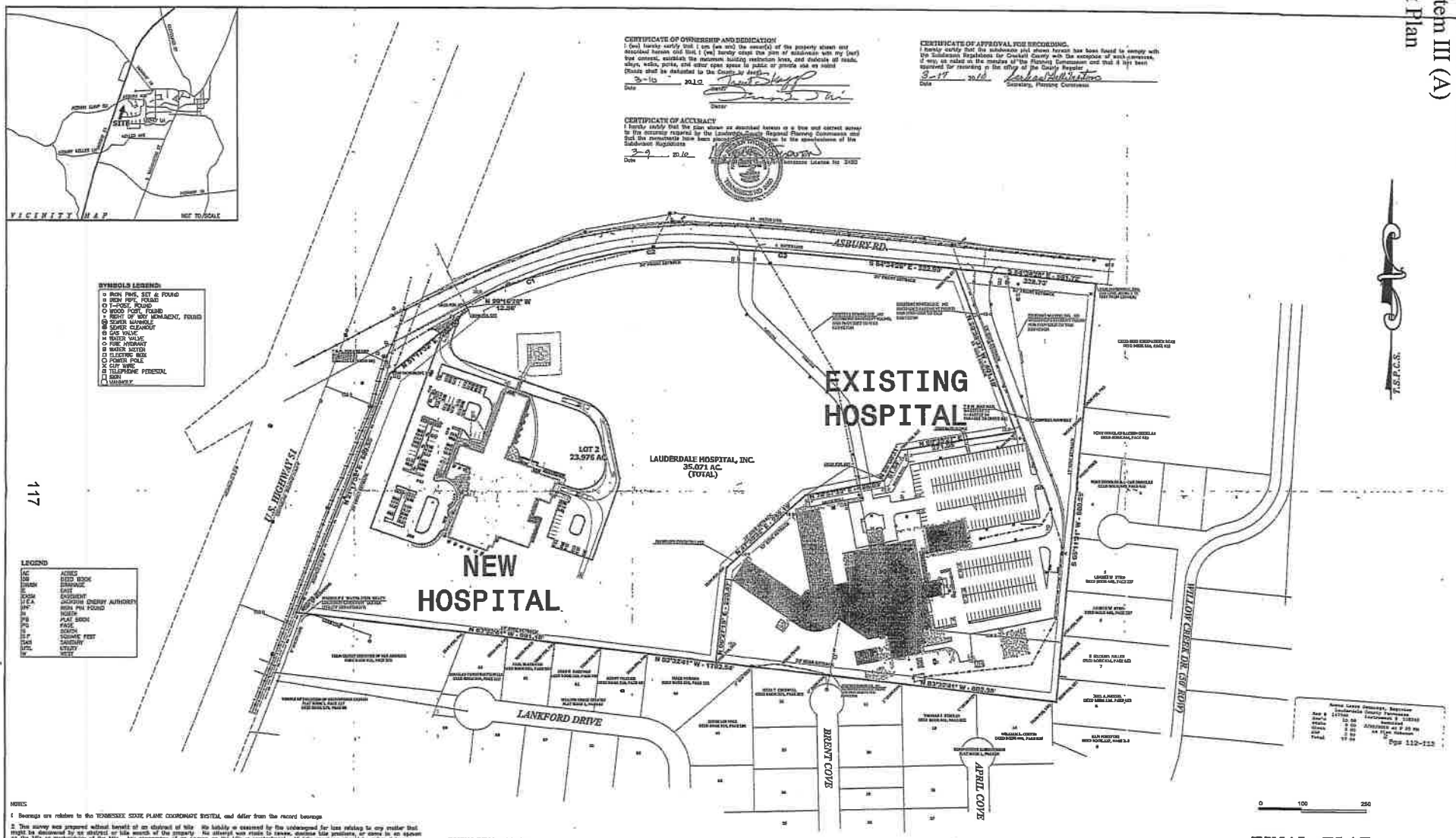
Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 6

Section B, Item III (A)

Plot Plan



FINAL PLAT

SCALE 1"=100' DATE 2-2-10
DRAWN BY M REGEN THORNTON, R.L.S 2480

SURVEY PREPARED FOR

LAUDERDALE HOSPITAL, INC.
LAUDERDALE COUNTY, TENNESSEE

2ND CIVIL DISTRICT, LAUDERDALE COUNTY, TENNESSEE
TAX MAP 94, PARCEL 27.04 – DEED BOOK 202, PAGE 274

SURVEYING SERVICES, INC
JACKSON, TENNESSEE
41 HERITAGE SQUARE
(731) 664-0907

DRW NO 2010-009

Lauderdale Community Hospital

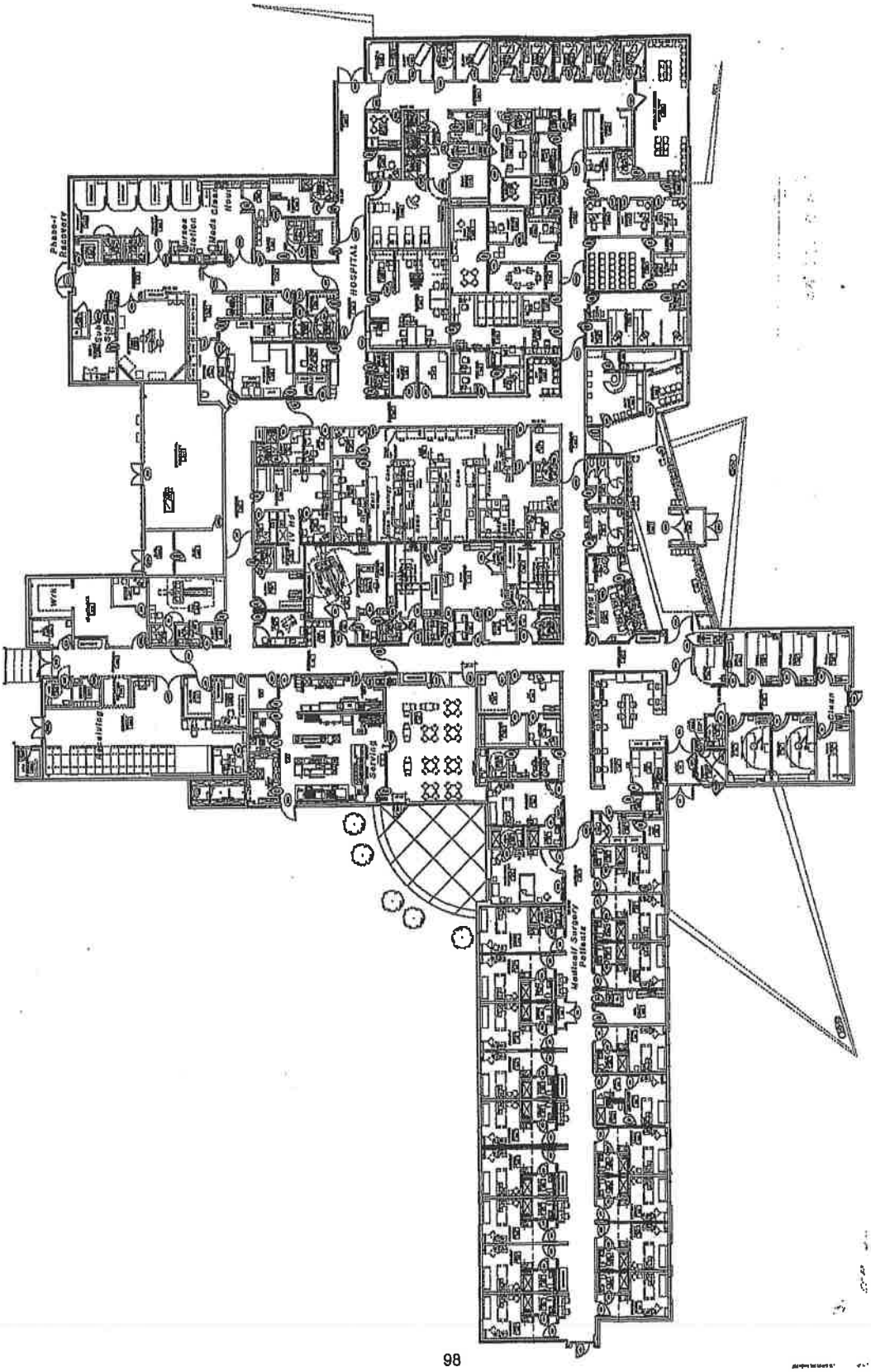
Tennessee Certificate of Need

Attachment 7

Section B, Item IV

Floor Plan

Attachment 7
Section B, Item IV
Floor Plan



Lauderdale Community Hospital

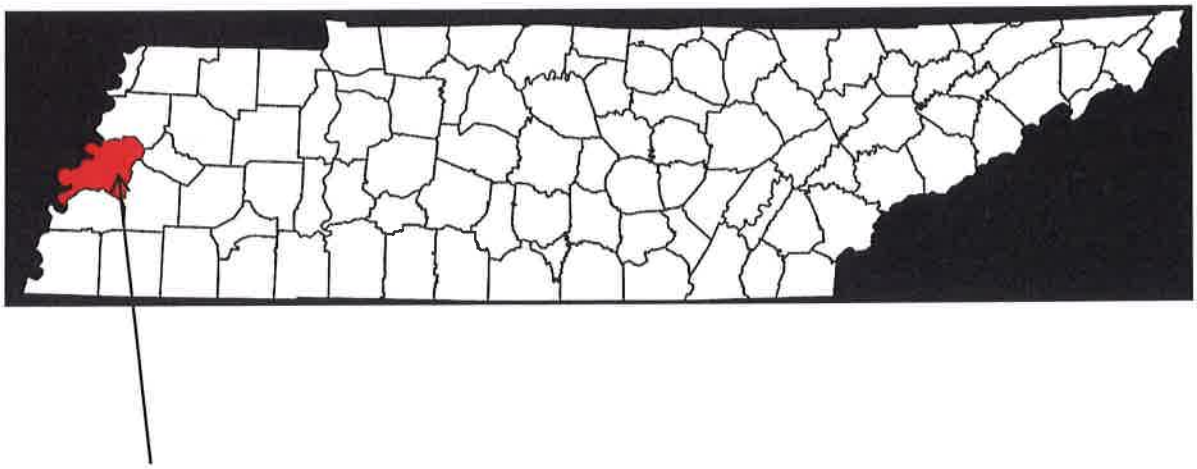
Tennessee Certificate of Need

Attachment 8

Section C, Need, Item 3

Map of Proposed Service Area

Attachment 8
Section C, Need, Item 3
Map of Proposed Service Area



Lauderdale County, Tennessee

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 9

Section C, Need, Item 6

7th Annual Rural Hospital Replacement Facility Study

How Replacement Facilities Impact Operations

Stroudwater Associates

SPECIAL INDUSTRY REPORT

Attachment 9
Section C, Need, Item 6
7th Annual Rural Hospital Replacement Facility Study

7th annual RURAL HOSPITAL REPLACEMENT FACILITY STUDY

2011

How Replacement Facilities Impact Operations

prepared and sponsored by STROUDWATER ASSOCIATES

sponsored by DOUGHERTY MORTGAGE LLC

NEENAN architruction

RURAL COMMUNITIES THAT HAVE BUILT A CRITICAL ACCESS HOSPITAL HAVE PIONEERED A NEW ERA. FIND OUT HOW A REPLACEMENT FACILITY IMPACTED THEIR OPERATIONS AND BOTTOM LINES.

THE 2011 RURAL HOSPITAL REPLACEMENT FACILITY STUDY IS PREPARED AND SPONSORED BY

Stroudwater Associates
800.947.5712

James C. Puiia, Senior Consultant
jpuiia@stroudwater.com

Eric K. Shell, Principal
eshell@stroudwater.com

Brian R. Haapala, Principal
bhaapala@stroudwater.com

SPONSORED BY
DOUGHERTY MORTGAGE LLC
NEENAN architecture

COVER PHOTOS: LEFT, TRI-VALLEY HEALTH CAMBRIDGE HOSPITAL, CAMBRIDGE, NE; RIGHT, MELISSA MEMORIAL HOSPITAL, HOLYOKE, CO.

The 2005, 2006, 2007, 2008, 2009 and 2010 studies are available at www.stroudwater.com

Design by anniecatherine, Portland, Maine.

TABLE OF CONTENTS

DELTA MEMORIAL HOSPITAL, DUMAS, AR

EXECUTIVE SUMMARY

In each of the past six years, the rural hospital replacement study has consistently shown that Critical Access Hospitals (CAHs) enjoy enhanced financial performance after replacement, in addition to other benefits such as higher employee retention and ease of recruitment. But the combination of a severe economic downturn and landmark healthcare reform legislation presents hospitals with a unique and perhaps unprecedented set of challenges. In 2010, the study began to examine the impact of the recent economic downturn on the performance of replacement facilities. This study looks further at the impact of the slumping economy and makes a first attempt to measure the performance of replacement CAHs against a standard which is becoming an increasingly important factor in healthcare reimbursement: quality.

The National Bureau of Economic Research declared the "Great Recession," which began in December of 2007, officially ended in June of 2009, making it the longest recession of the post World War II era. Even now, more than two years later, the effects of the recession linger and the outlook calls for a long, slow recovery to pre recession economic vitality. From 2004 through 2010, the Centers for Medicare & Medicaid Services (CMS) reported average annual growth in hospital discharges of only 1.6 percent and growth in patient days of only 0.3 percent annually. Many hospitals reported declining patient volumes in multiple lines of service.

The experiences of those facilities replaced during and immediately following the recession are most instructive to those considering replacement in the near future. In 2010, additional focus was added to examine the performance of hospitals replaced during 2006 and 2007, immediately before the recession, compared to those facilities replaced in earlier years. But performance data from those newest replacements was limited. In the 2011 study, the impact of the recession is further examined by adding more hospitals to the study, gathering an additional year of performance data for those hospitals replaced in 2006 and 2007, and taking a first look at the performance of those hospitals that opened during and even after the official end of the recession. With data from 114 rural hospital replacement facilities, Stroudwater focused additional analysis on those facilities which experienced their first years of operation during this difficult economic period. The results show that these facilities fared well. Rural facilities replaced during the period between 2006 and 2010 experienced solid growth in patient volumes as measured by patient days, outpatient visits, and adjusted patient days.

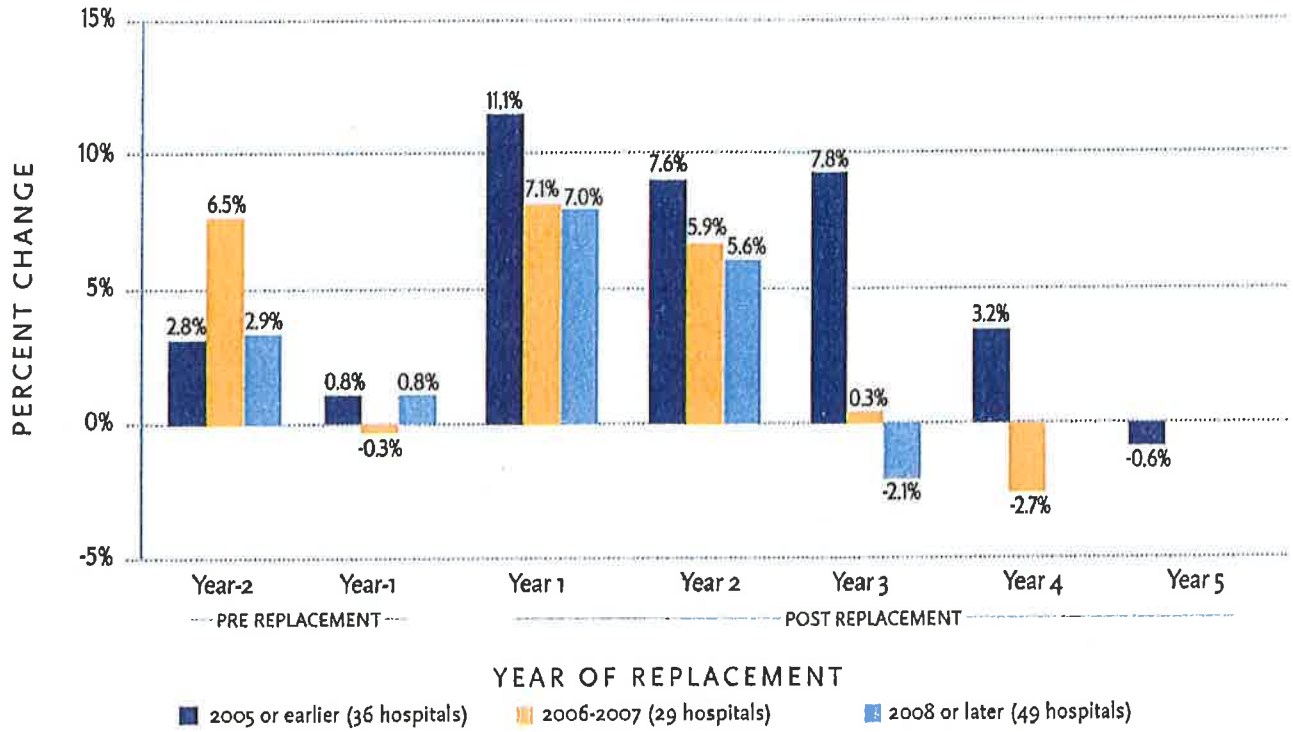
NEW FOR THE 2011 STUDY

- 23 new CAHs participating; a 25 percent increase over the number of 2010 participants
- New segmentation of hospitals based on year of replacement
  - 2005 and earlier (pre recession)
  - 2006-2007 (recession)
  - 2008 or later (post recession)
- Reporting on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores

Looking more closely at the data, hospitals' experiences differed based on when the facilities were replaced. Hospitals were separated into three time-based cohorts: facilities replaced in 2005 or earlier (pre recession), facilities replaced in 2006 and 2007 (recession), and facilities replaced in 2008 and 2009 (post recession). As shown in the chart on the next page, hospitals in all three groups experienced strong volume growth in the first and second years of operation following replacement. The pre recession replacement hospitals were able to sustain substantial volume growth even beyond the first

two years of operation. Those replaced during the recession had no volume growth in the third year and lost volume in the fourth year following replacement. The post recession replacements lost volume in the third year of operations. Because many of the measures in this study are based on patient volume or are driven by patient volume, this pattern of results was repeated in performance with regards to staffing, operating costs, and profitability.

MEDIAN PERCENT CHANGE IN TOTAL PATIENT VOLUME
By Year Pre and Post Replacement



"The results of the study suggest that a replacement facility can be a platform for a financially viable hospital delivering a high quality patient experience."

While higher quality of care and a better patient experience are expectations of a new hospital facility, they are not assured. In 2011, CMS released data to be used for the Medicare Value Based Payment Program (VBPP) which included quality-related measures reported by all hospitals, including CAHs. Replacement CAHs scored higher than CAHs in general on every measure of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Additionally, replacement CAHs reported HCAHPS scores that would qualify for incremental payments under VBPP. While this program is currently not applicable to CAHs, research is underway to develop a similar program which would adjust CAH reimbursement based on quality measures.

While the challenges of a slow economy and healthcare reform will remain as important considerations for several years to come, the results of the study suggest that a replacement facility can be a platform for a financially viable hospital delivering a high quality patient experience.

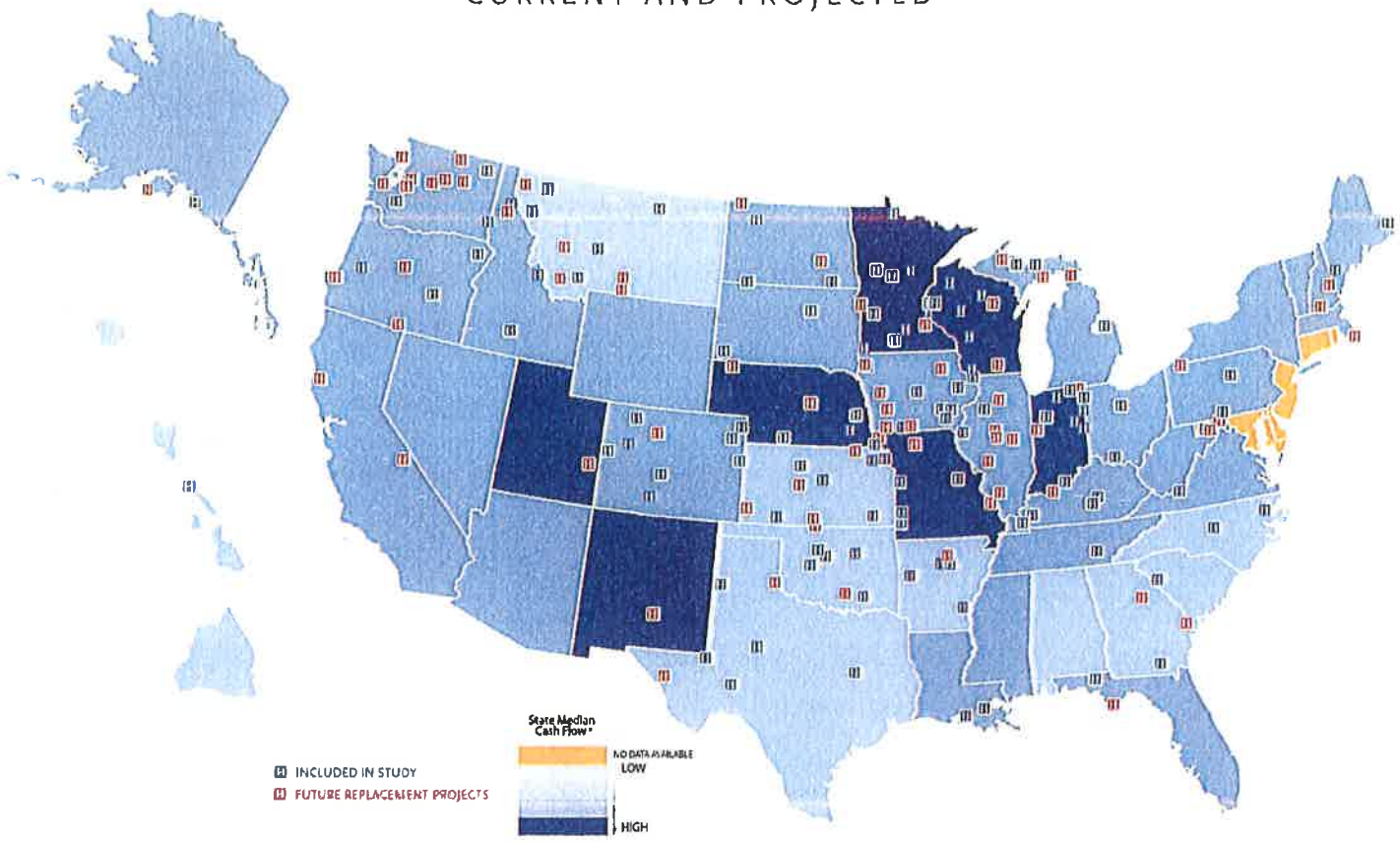
MCCUNE-BROOKS REGIONAL HOSPITAL, CARTHAGE, MO

Purpose

When the study began in 2005, few resources existed for rural hospital leadership, boards, and community leaders to assist them in understanding what a new replacement facility hospital would do to or for their bottom line. The study's purpose is to gather and present quantitative and qualitative data from communities that have replaced their Critical Access Hospital (CAH) to educate those considering, embarking on, or in the midst of a replacement facility project.

The study typically generates discussion around a replacement in three pivotal areas: Driving Factors (why would we replace?); Access to Capital (what can we afford?); and the Role of Leadership (how do we do this?).

ELIGIBLE CAH REPLACEMENT FACILITIES: CURRENT AND PROJECTED



*Median cash flow margins for all CAHs within each state, as reported by the Flex Monitoring Team, August 2011

Eligibility

With the assistance of State Office of Rural Health and State Hospital Association representatives, a list of candidates is established. Stroudwater then validates the candidate list and ensures the eligibility criteria are met:

- Hospitals had Critical Access Hospital designation prior to replacement
- Opened clinical areas between January 1, 1998 and January 1, 2010
- Operations in the community for at least three years prior to replacement

Validated hospitals are included in the study. From 2005 to 2011 the number of hospitals included in the study has increased from 20 to 114. As shown on the map above, there are many other replacement projects underway or in the planning process.

Process

The methodology established in 2005 and followed in each subsequent year of the study was developed and vetted by an advisory panel which included governmental, academic, and financial experts as well as a national non-profit entity whose mission is to build capacity in rural hospitals. Quantitative and qualitative data contribute to the methodology.

The 2011 study uses publicly available cost report data, input from hospital CEOs and CFOs, the American Hospital Association Guide and the American Hospital Directory. The quantitative data analyzed for the purposes of the study include: volumes (patient days, outpatient visits, adjusted patient days), operating efficiency (gross Full Time Equivalents or FTEs, FTEs per adjusted patient day, operating expense per adjusted patient day) and financial results (operating margin, EBIDA, days cash and investments on hand).

Interviews with a sample of hospital CEOs and CFOs were conducted in prior years' studies to complement and further examine the quantitative data. The interviews focused on any impact, whether positive or negative, the replacement facility had on quality, staff recruitment and retention, and the economy of the local community. While no interviews were conducted with the facilities added to this year's study, the body of data gathered from historical interviews still forms an important component of the total findings in the study.

"In the first year following replacement, all groups experienced growth in total patient volume,..."

Design

A CAH's market potential, level of competition, physician support, management experience, historical financial performance, access to capital, and more are unique to the community served. To begin to control for these differences, the study compares data from before the replacement project to data after, with Year 1 for each hospital being the first year in which the hospital operated in its new facility for at least 6 months.

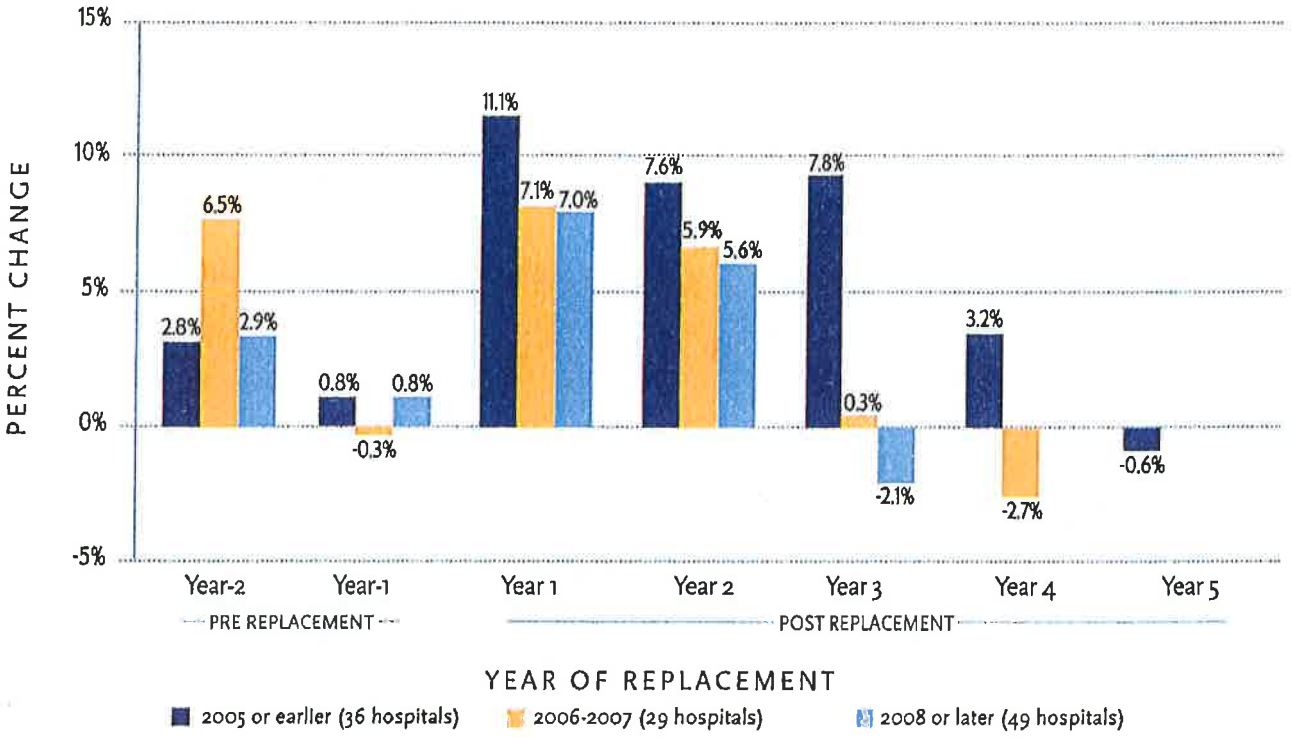
Volume Experiences

To label the new facilities included in this study as "replacements" may be a bit of a misnomer. Although each is different in overall scope, complexity, and volume levels, CAHs provide more outpatient than inpatient services. And these new facilities are designed to reflect the increased emphasis on ambulatory service. As such, to evaluate total volumes across such a varied spectrum, the study uses the industry standard approach of creating an overall measure of volume that takes both inpatient and outpatient volume into account. "Adjusted patient days" reflects in a common measure the total activity for different hospitals with different mixes of services provided.

Median volumes for all three cohorts of replacement CAHs were flat in the year prior to replacement. In the first year following replacement, all groups experienced growth in total patient volume, with those replaced in 2005 or earlier experiencing the largest post replacement increase of 11 percent, compared to 7 percent and 6 percent growth for the 2006-2007 cohort and the 2008 or later cohort, respectively. Additionally, the volume growth for the 2005 or earlier cohort continued longer and at greater levels than for the other two cohorts of replacement CAHs. Of the 114 participating hospitals, 27 (24 percent) reported accumulated volume losses post replacement, and 18 of those 27 were facilities replaced in 2008 or later.

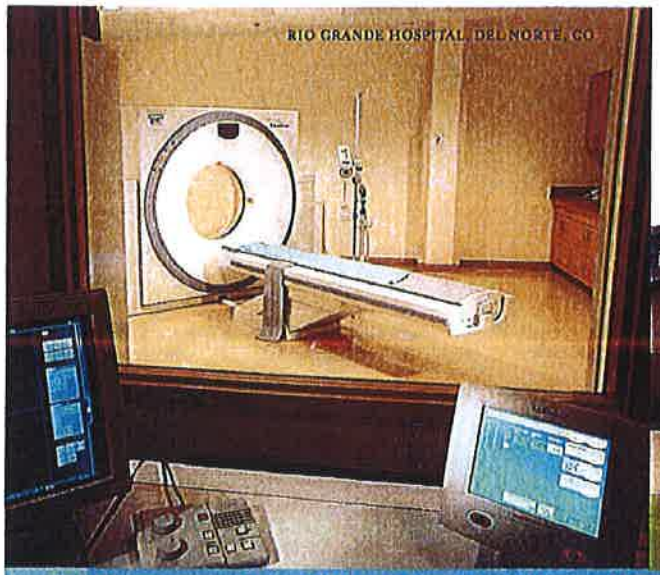
MEDIAN PERCENT CHANGE IN TOTAL PATIENT VOLUME

By Year Pre and Post Replacement



YEAR OF REPLACEMENT

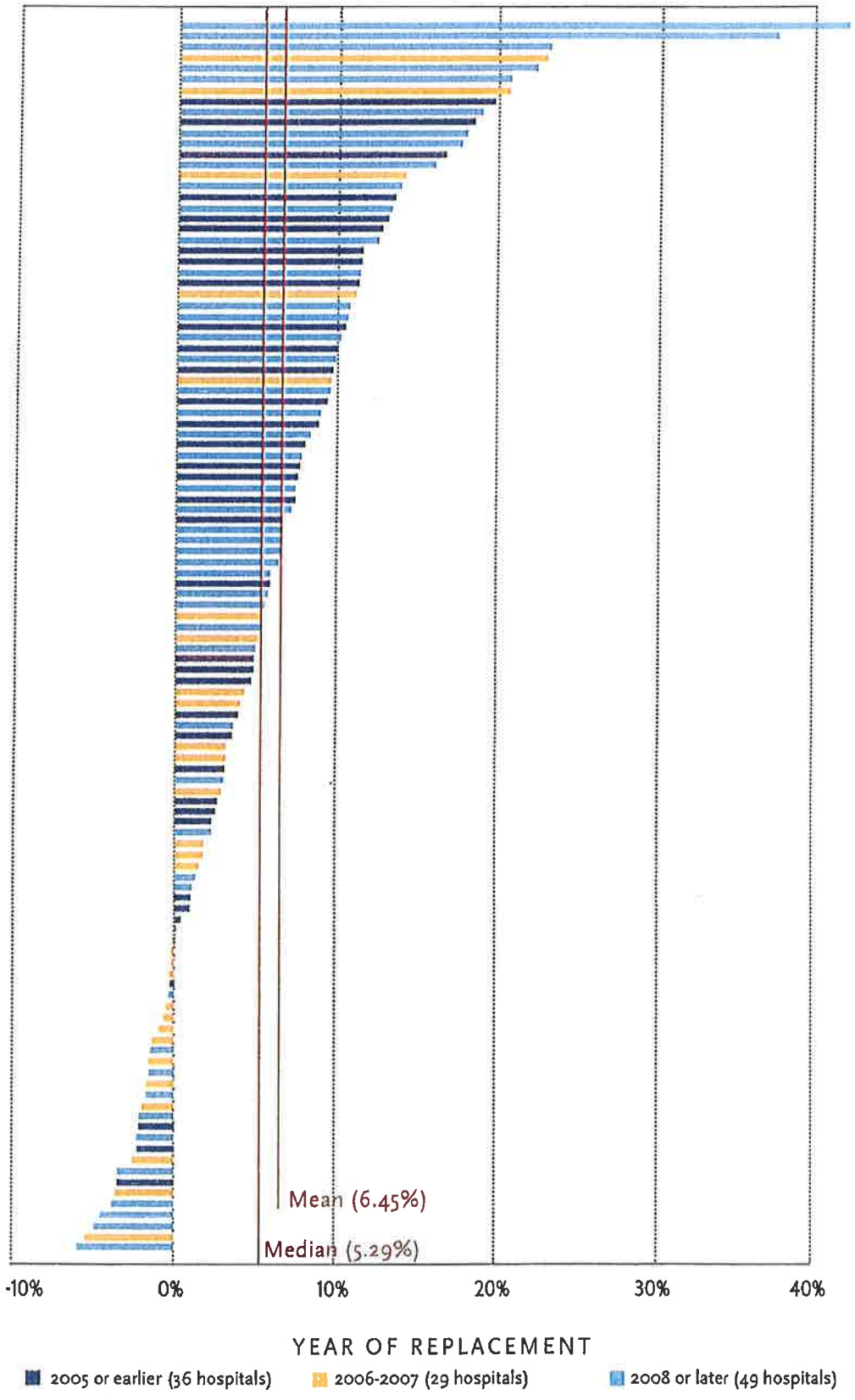
■ 2005 or earlier (36 hospitals) ■ 2006-2007 (29 hospitals) ■ 2008 or later (49 hospitals)



PHILLIPS COUNTY MEDICAL CENTER, MALTA, MT

PERCENT CHANGE IN TOTAL VOLUME

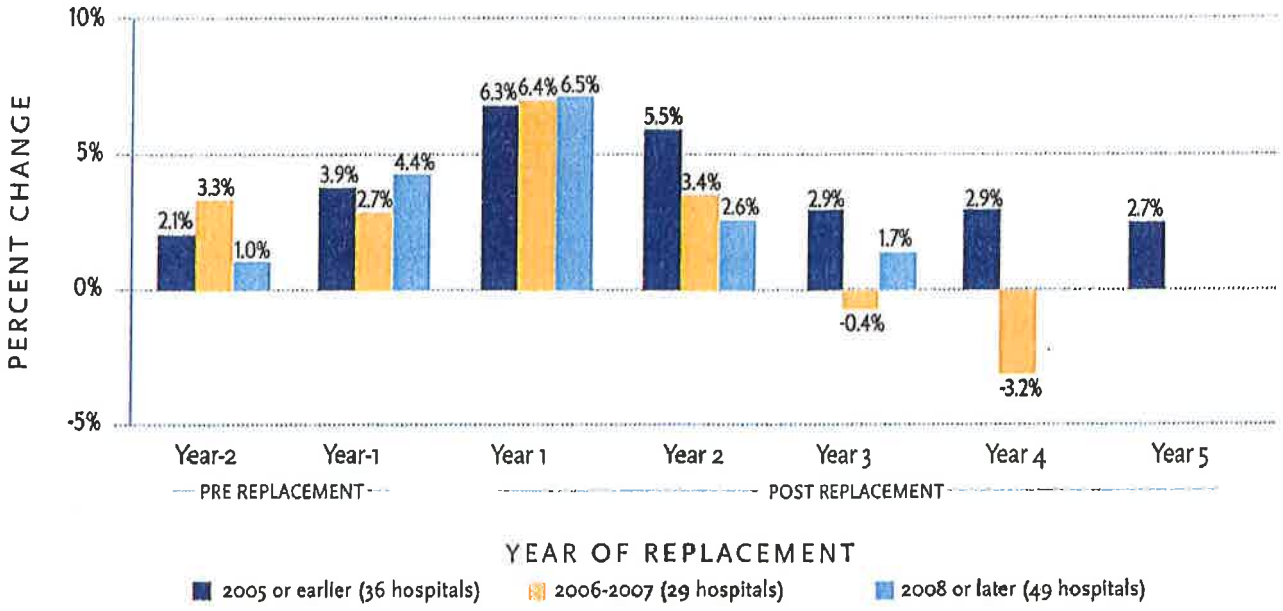
Average annual change for all years post replacement



While median values provide us with guidance regarding the general experience of the group, the results for individual facilities vary greatly from those medians.

The graph to the left exhibits, for each facility, the average annual change in total volume for all years post replacement, ranging from a single year for the newest replacements up to five years for older replacements. The median annual growth rate for all hospitals for all years is 5.29 percent, but the volume changes range from a decrease of 6 percent to an increase of nearly 43 percent. Twenty-six of the 114 participating hospitals experienced declines in total volume. Half of those facilities which lost volume were replaced in 2005 or earlier, but the larger volume declines generally occurred in the most recent replacements. Similar variability was experienced in the other measures presented in this study.

MEDIAN PERCENT CHANGE IN STAFFING
By Year Pre and Post Replacement



Staffing

Rural hospitals are often challenged with staff shortages, particularly with physician and other clinical professionals. The ability to both recruit and retain highly qualified professionals is integral to the health of an organization.

An enhanced ability to recruit higher quality personnel following replacement was cited by several of the CEOs interviewed. In particular, CEOs indicated that the promise of a new facility played a key role in the recruitment of physicians, who ultimately contribute to the volume growth discussed above. A number of facilities reported discontinued use of agency staffing and reduced turnover rates. Many organizations reported having no nursing vacancies and several indicated they have waiting lists.

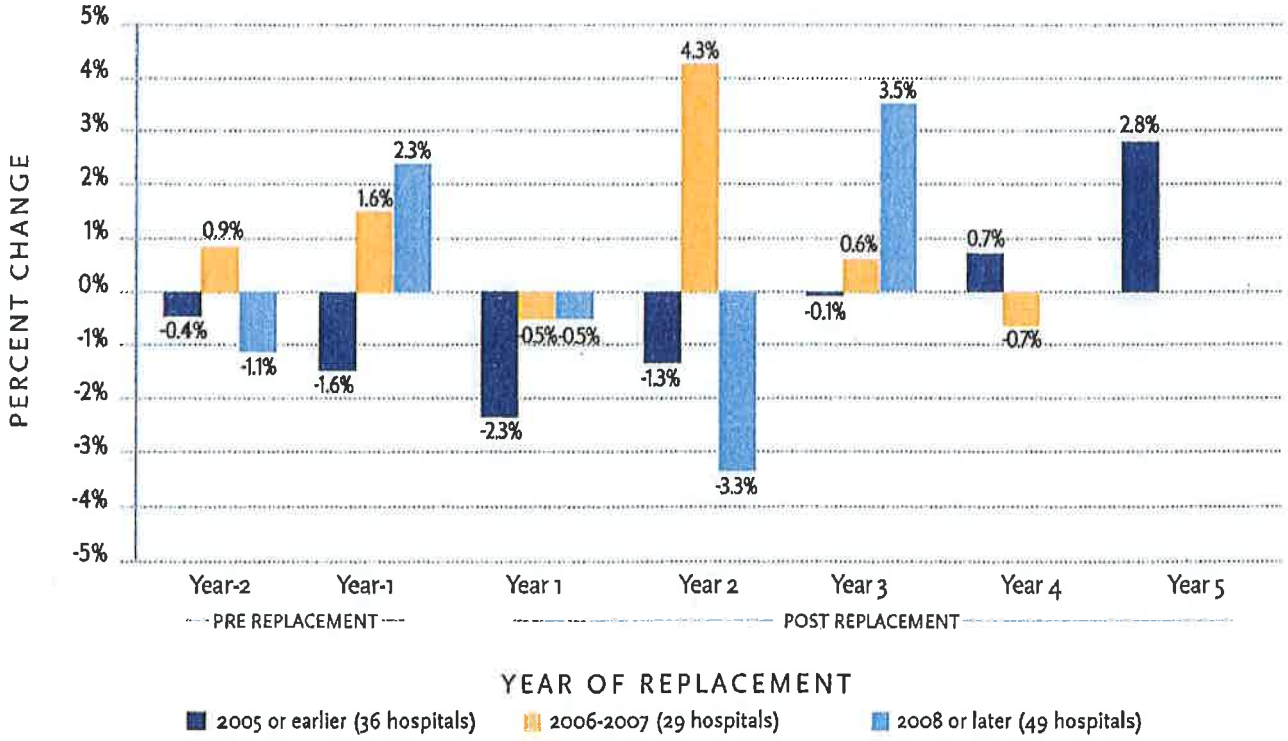
All facilities increased staffing at higher rates in their first post replacement year to support new volume being served by the facility. Hospitals replaced in 2005 or earlier continued to increase staff at a faster pace for the second year after replacement and by the third year had returned to growth rates similar to their pre replacement period. Hospitals replaced during 2006 and 2007, and 2008 or later slowed staffing increases back to pre replacement pace in Year 2, and by Year 3 were hiring at a slower pace than before replacement. This may be a result of the difficult economy as well as the less robust volume growth experienced by these facilities.

Even with higher staffing overall, the number of staff per unit of service (defined as Adjusted Patient Days) decreased on average for all replacement groups in the first year post replacement. This measure reflects improved efficiencies in the operations. However, facilities replaced in 2006-2007, and 2008 or later, saw declines in efficiency in the second and third years post replacement, as increased staffing was not matched by continued increases in volume. Approximately half of all participating hospitals experienced improved post replacement efficiency, with those hospitals replaced in 2005 or earlier being more likely to have improved efficiency.

"Approximately half of all participating hospitals experienced improved post replacement efficiency."

MEDIAN PERCENT CHANGE IN STAFFING EFFICIENCY

By Year Pre and Post Replacement



YEAR OF REPLACEMENT

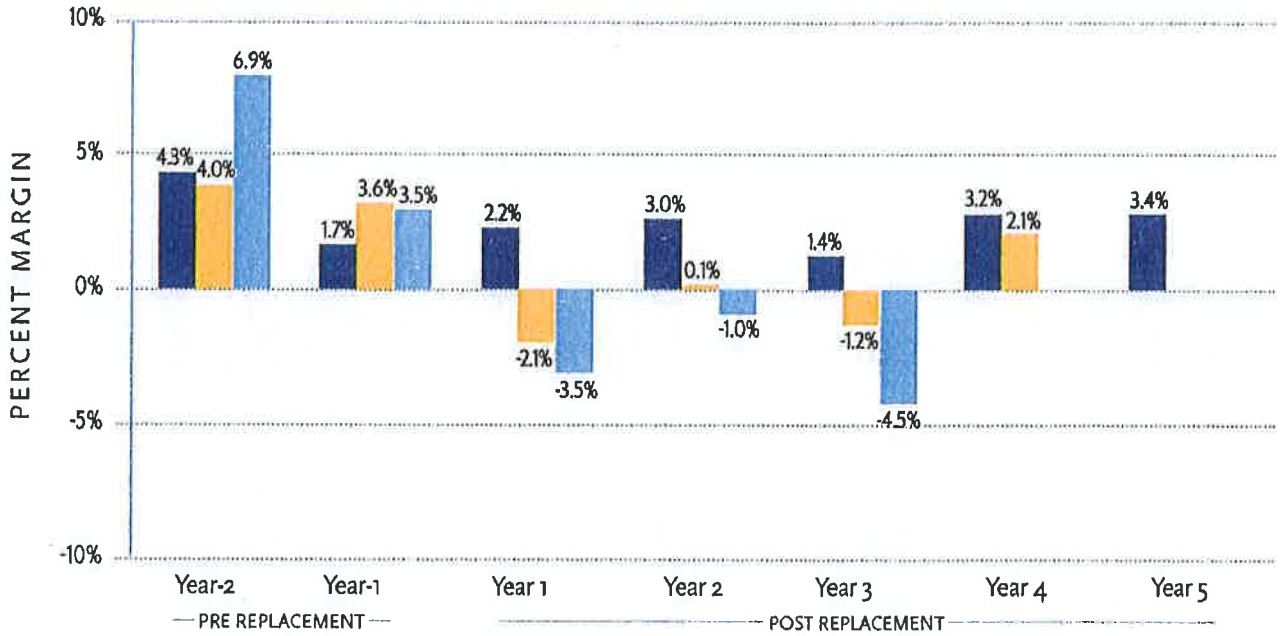
2005 or earlier (36 hospitals) 2006-2007 (29 hospitals) 2008 or later (49 hospitals)

FINANCIAL PERFORMANCE

Total Margin

Facilities replaced in 2005 or earlier maintained total margins post replacement, as increased volume offset increases in facility costs, specifically interest and depreciation, and the cost of additional staffing. Those hospitals replaced in 2006-2007, and 2008 or later, saw margins decline as the volume increases post replacement were not enough to offset the higher costs. Facilities need to closely manage budgets in the first years following a facility investment in order to realize the benefits from any increases in patient volume.

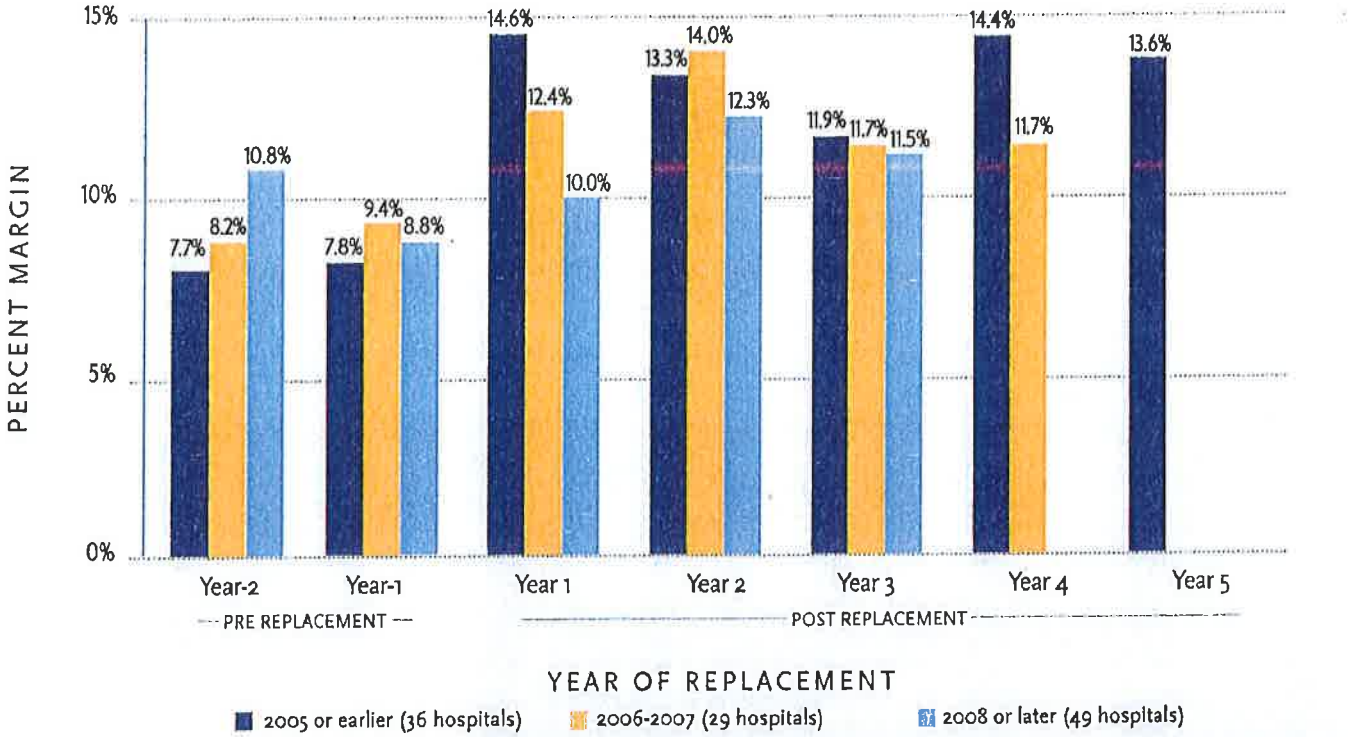
MEDIAN TOTAL MARGIN
By Year Pre and Post Replacement



YEAR OF REPLACEMENT

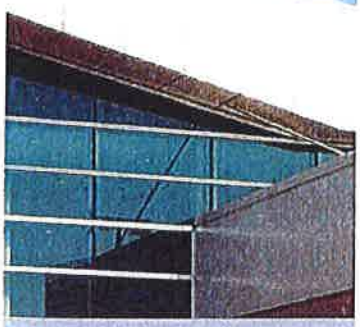
■ 2005 or earlier (36 hospitals) ■ 2006-2007 (29 hospitals) ■ 2008 or later (49 hospitals)

MEDIAN EBIDA MARGIN
By Year Pre and Post Replacement



EBIDA Margin

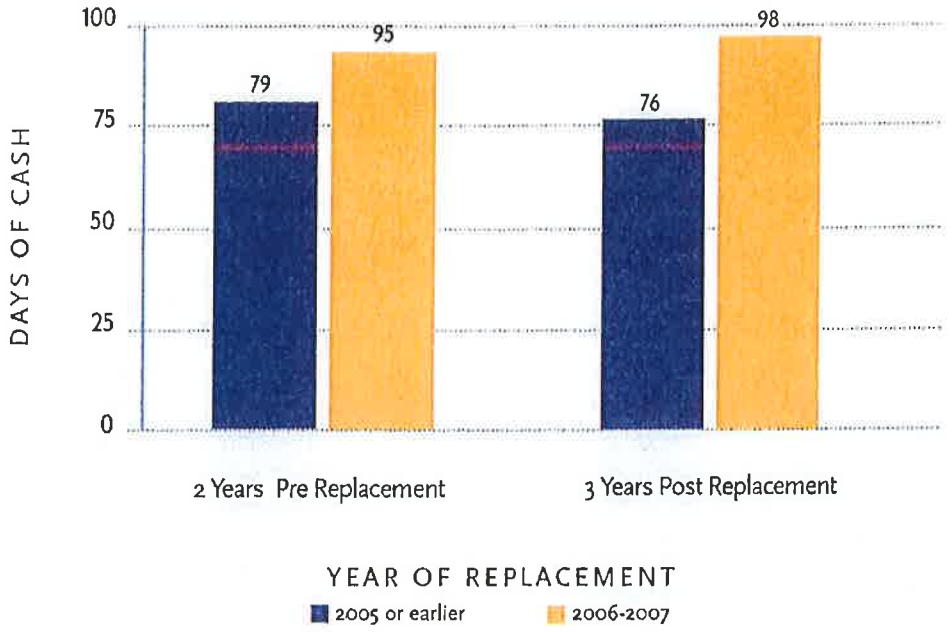
Earnings Before Interest Depreciation and Amortization (EBIDA) is a measure that approximates cash flow. It displays less variation than total margin, and replacement CAHs in all three categories showed improvement in EBIDA post replacement. This suggests that the lower margins experienced by more recent replacements are driven by higher capital costs, specifically depreciation and interest, rather than operating costs, such as salaries. Boards generally target an EBIDA margin that reflects enough cash flow to sustain operations through the startup of the new facility.



"All three cohorts of hospitals maintained cash levels on hand after replacement."

AVERAGE DAYS CASH AND INVESTMENTS ON HAND

65 Hospitals with at Least Three Years Post Replacement Data



Average Days Cash on Hand

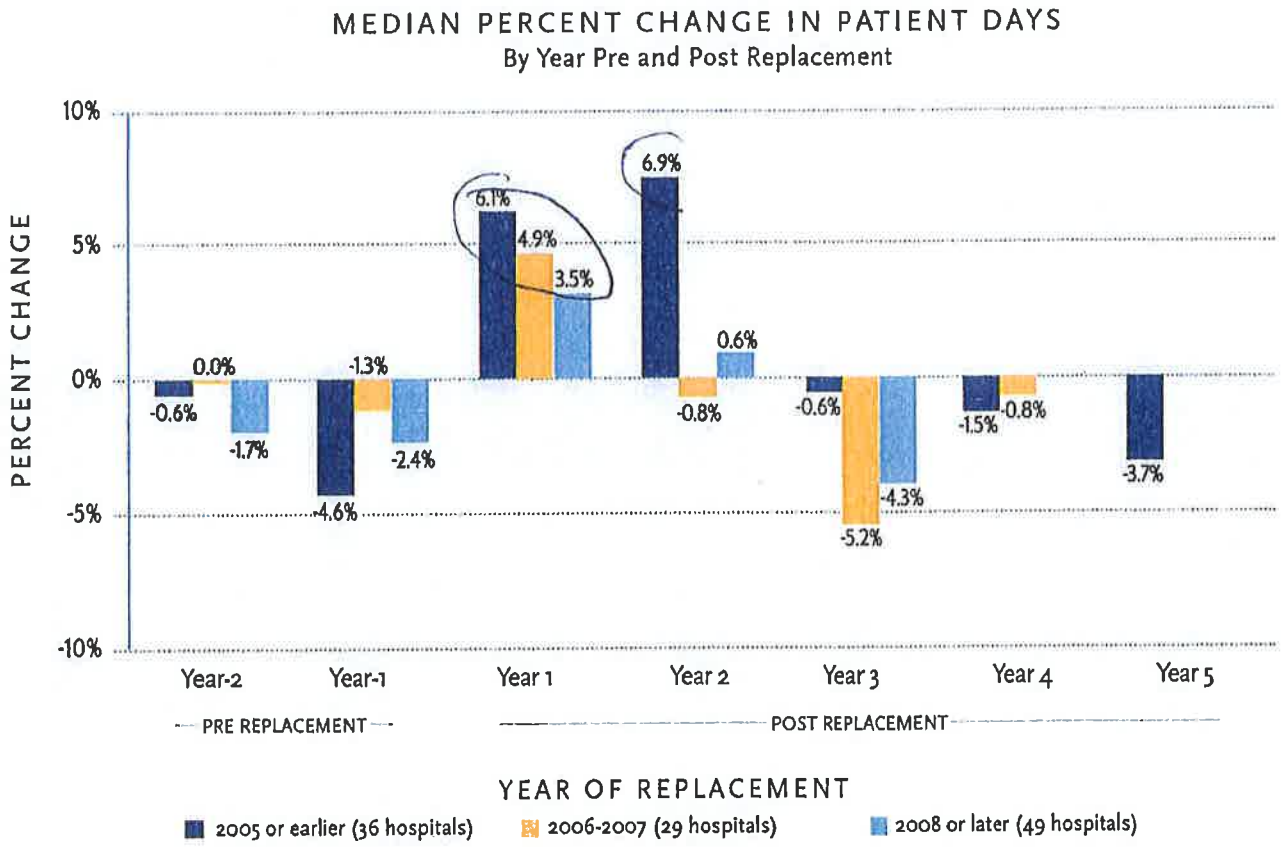
Post replacement days cash on hand varies with overall financial performance, the facility's initial reserves, and the amount of borrowing required to fund the replacement facility. Lenders evaluate cash on hand both prior to and following replacement to ensure working capital is sufficient.

All three cohorts of hospitals maintained cash levels following replacement. Cash on hand in the years immediately preceding replacement can fluctuate greatly due to the influx of cash borrowed for construction. Looking at the average of several years before and after replacement, those hospitals replaced during 2006 - 2007 had more cash on hand before replacement than facilities replaced in 2005 or earlier, but both groups maintained cash levels after replacement that were similar to their cash levels before replacement.

The study uses adjusted patient days as the measure for total patient volume, reflecting the combined impact of changes for both inpatient and outpatient services. The data on this page are presented to show the replacement hospital experiences for inpatient and outpatient volumes separately. Data reflect year-to-year changes: growth shown from one year to the next is incremental to any change in volume reported in the previous year.

Inpatient Volumes

Pre-replacement inpatient volumes were flat or decreasing, with median volume changes falling for all three replacement groups in the year just before replacement. The post replacement data show that all three groups experienced increases in patient days in the first year following replacement. Those hospitals replaced in 2005 or earlier showed the largest increase, with median growth of 6.1 percent, compared to a 4.9 percent increase for hospitals replaced in 2006-2006 and a 3.5 percent increase for hospitals replaced in 2008 or later. The 2005 or earlier hospitals also recorded a large increase in inpatient volume during the second year after replacement, while both groups of later replacements saw inpatient activity level off in Year 2. Inpatient volume levels fell for all three cohorts in Years 3, 4 and 5, though the losses were less in those hospitals replaced in 2005 or earlier.



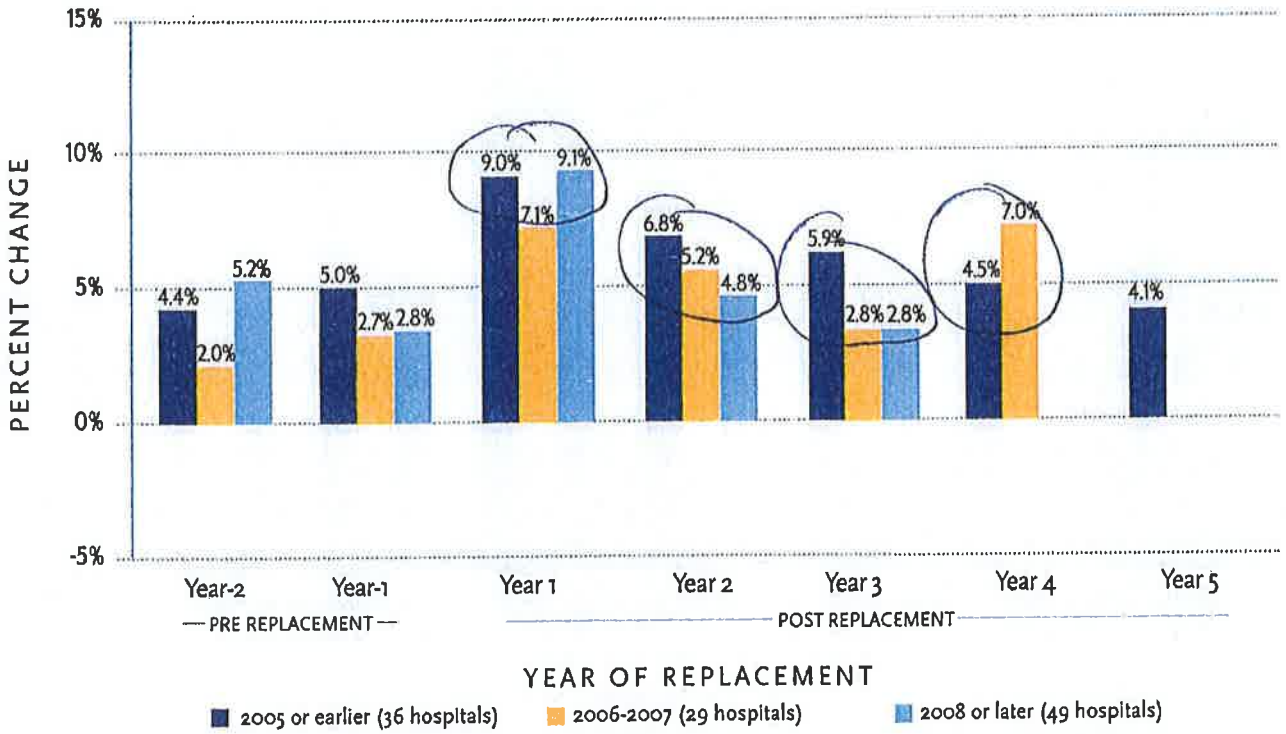
Outpatient Volume

Outpatient service volumes were growing approximately 3-5 percent per year prior to replacement. In the first year following replacement, outpatient volumes grew from 7-9 percent, with each replacement group experiencing at least 4 percent higher growth than pre replacement. The higher growth levels continued through the second post replacement year. By Year 3, growth in all three groups had returned to pre replacement levels.

Quality

While higher quality of care and a better patient experience are expectations of a new hospital facility, they are not assured. As both public and private payers place increased emphasis on quality as a determinant in hospital reimbursement, organizations contemplating a replacement facility need to understand how these future reimbursement methods will affect them. Because CAHs are not required to report quality data, there are not large amounts of data available. However, in 2011 CMS released data to be used for the Medicare Value Based Payment Program (VBPP) which included quality-related measures reported by all hospitals, including CAHs. Only about 20 percent of CAHs reported core quality measures on patient care processes and outcomes. But approximately half of all CAHs reported scores for the Hospital Consumer Assessment of Healthcare Providers

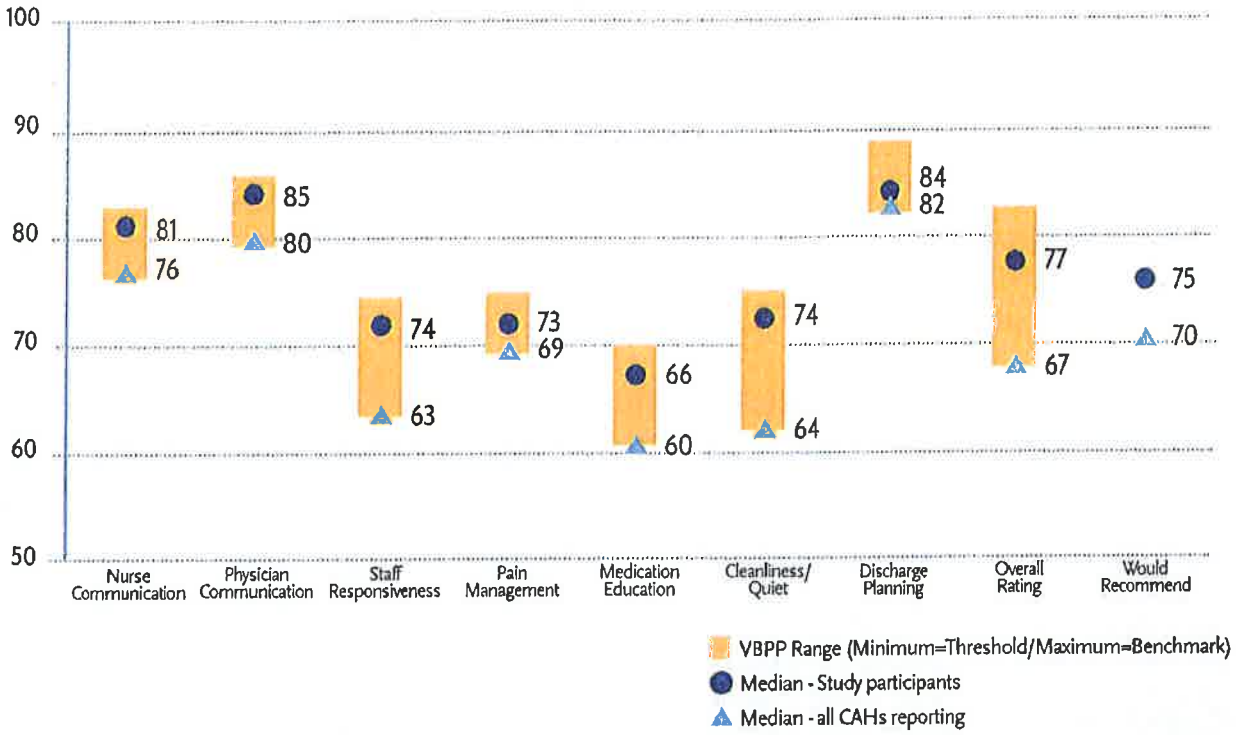
MEDIAN PERCENT CHANGE IN OUTPATIENT VISITS
By Year Pre and Post Replacement



HCAHPS PERFORMANCE: REPLACEMENT CAHS VS. ALL CAHS

July 1, 2009 through March 31, 2010

(Baseline period for Medicare Value Based Purchasing Program)



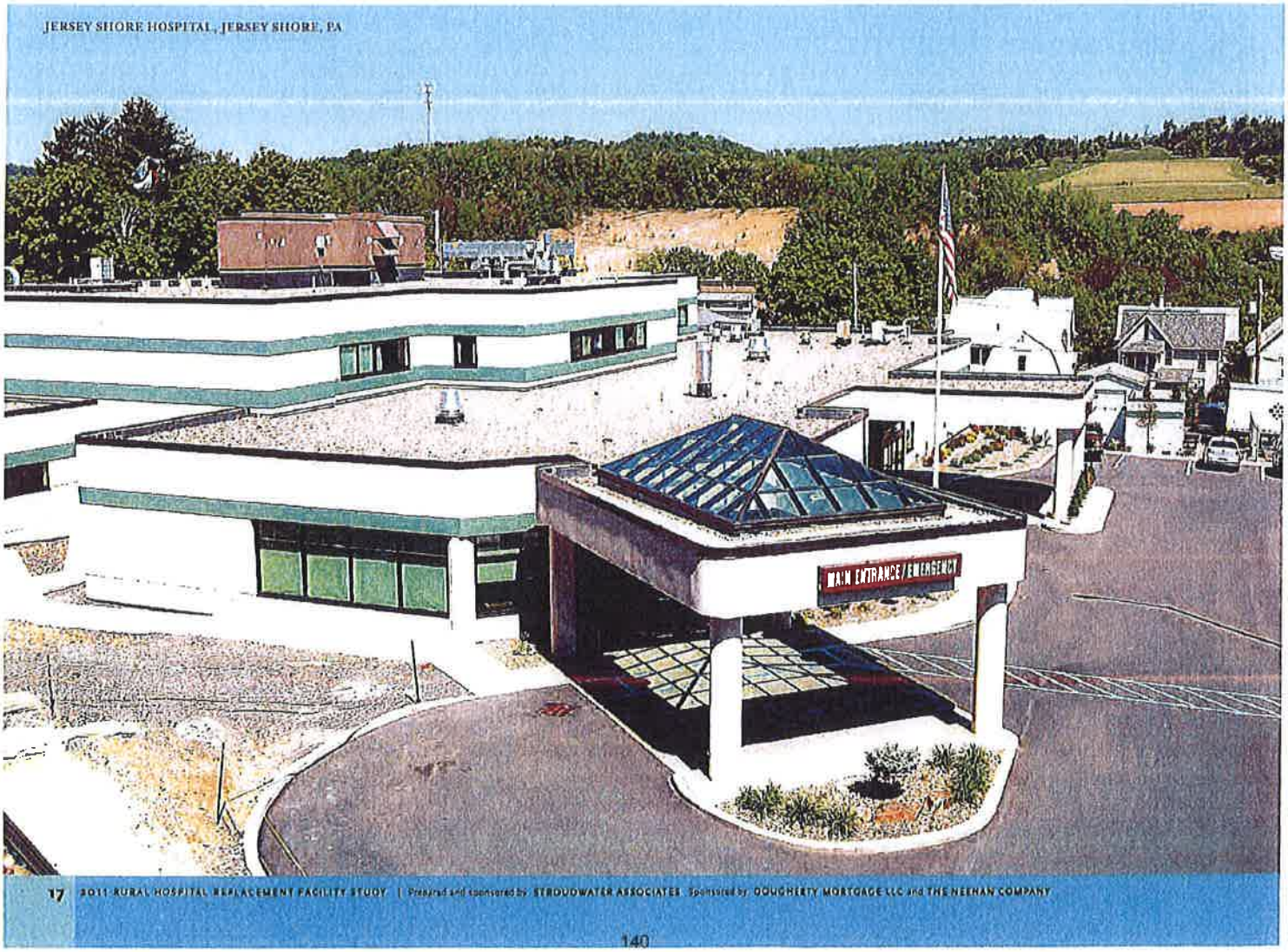
and Systems (HCAHPS) survey, which measures patients' perceptions of their hospital experience. A review of the data indicated that replacement CAHs reported HCAHPS scores at approximately the same rate as CAHs in general, allowing for comparison of the performance of replacement CAHs to the universe of CAHs.

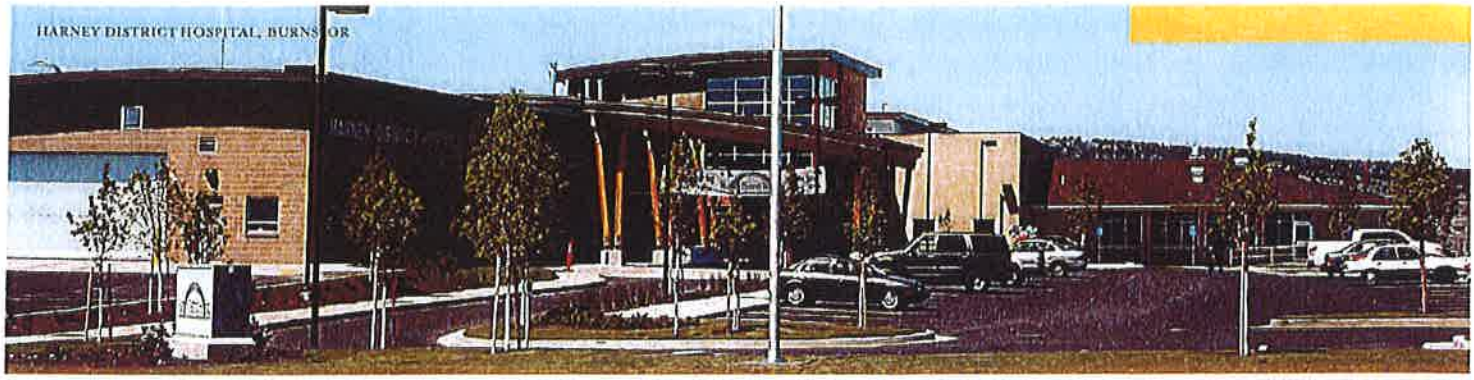
As indicated on the graph above, replacement CAHs scored higher than CAHs in general on every HCAHPS measure. Additionally, replacement CAHs reported HCAHPS scores that would qualify for incremental payments under VBPP. While this program is currently not applicable to CAHs, research is underway to develop a similar program which would adjust CAH reimbursement based on quality measures.

"...replacement CAHs scored higher than CAHs in general on every HCAHPS measure."

CONCLUSIONS

Critical Access Hospitals, like all hospitals, face challenging times. Hospitals are still reimbursed based on the volumes of services provided, but a down economy has dampened demand for services. And patients are being given more responsibility for paying for those services, increasing hospitals' levels of bad debt and charity care. Healthcare reform is placing more emphasis on value, requiring hospitals to either lower costs or provide higher quality for the same price. This combination of factors might suggest to some that now is not the time for CAHs to replace their facilities. But the combination of increased outpatient volume, increased efficiency, improved EBIDA margin and higher HCAHPS scores might suggest that for some CAHs a replacement facility is a necessary element for future success.





STROUDWATER ASSOCIATES

Stroudwater Associates is a prominent healthcare advisory firm with a dedicated team that is passionate about the health of rural people and places. With offices in Portland, Maine and Atlanta, Georgia Stroudwater provides strategic, financial, facility planning, and operational consulting services to a national clientele — from academic medical centers to small, rural hospitals, and from integrated health systems to stand-alone community hospitals.

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Research and analysis conducted with the assistance of Julie Spalding, M.H.A. Candidate, Sloan Program in Health Administration, Cornell University, Intern Summer 2011

DOUGHERTY MORTGAGE LLC

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THE NEENAN COMPANY

The Neenan Company has provided integrated design and construction services in the healthcare industry for more than 20 years. In the past 10 years, Neenan has completed over 200 healthcare projects totaling over 2,000,000 square feet of healthcare projects across the United States. The Neenan Company collaborates with our clients in transforming their built environment, facilitating improved patient access and a heightened quality of care. At Neenan, we bring together professionals of many disciplines to work concurrently, under one roof – entwining planning, design, functionality, performance and cost – to create sustainable facility solutions for our clients. We serve physician groups, hospitals, and healthcare providers across the nation to transform their organizations through their facilities.

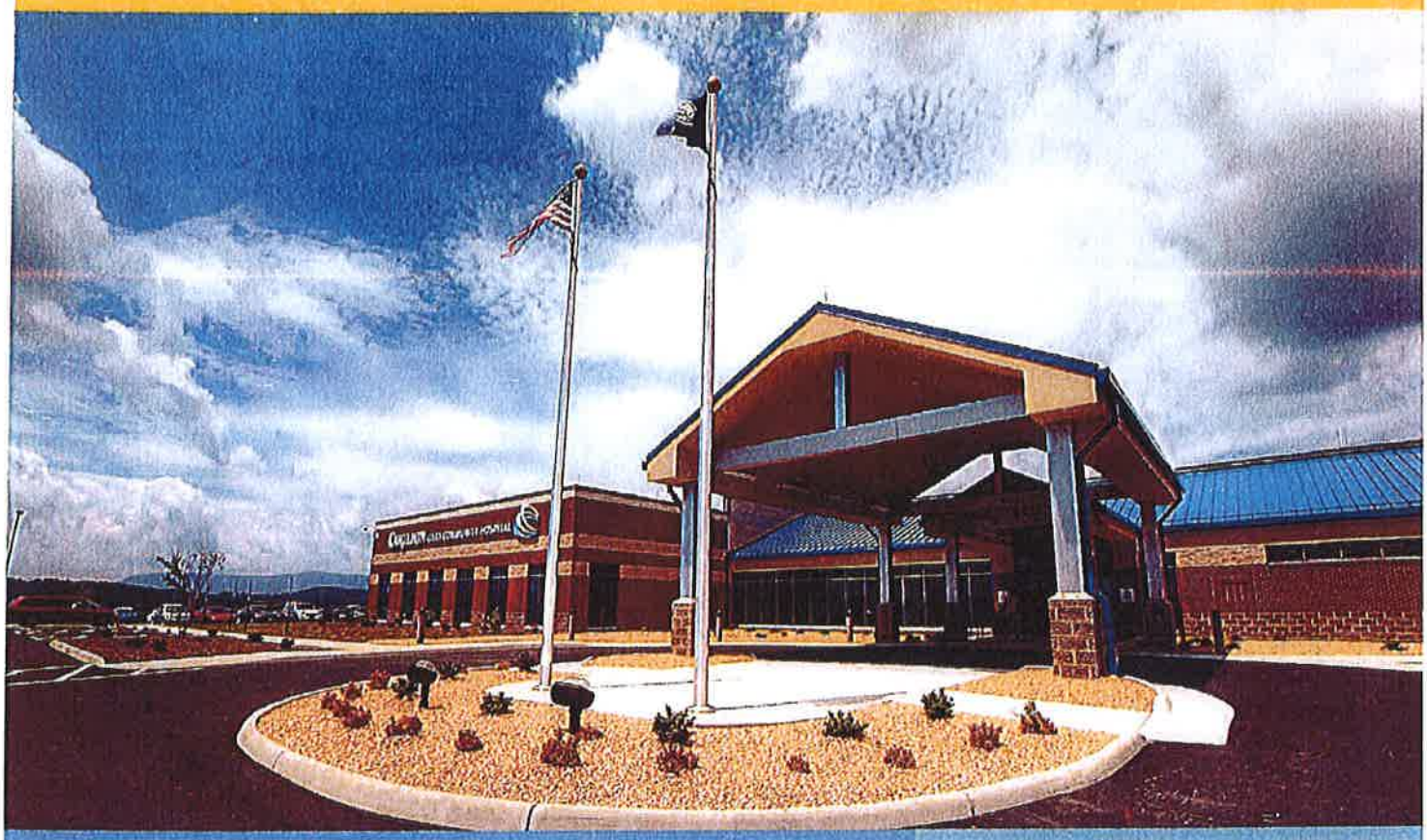
Michael Curtis, Vice President Business Development, 303.710.1873 michael.curtis@neenan.com

2011 DIRECTORY

FACILITY NAME	STATE	ADMIN/CEO	TEL	POP
Abbeville Area Medical Center	SC	Rich Osmus	864-366-5011	17,869
Adams County Regional Medical Center	OH	Saundra Stevens	937-386-3400	31,306
Adams Memorial Hospital	IN	Marvin Baird	260-724-2145	42,402
Amery Regional Medical Center	WI	Michael Karuschak	715-268-8000	26,823
Atchison Hospital	KS	John Jacobson	913-367-2131	17,889
Atoka County Medical Center	OK	Paul Reano	580-889-3333	13,321
Baptist Health Medical Center - Heber Springs	AR	Edward Lacy	501-887-3000	23,322
Barton County Memorial Hospital	MO	Rudy Snedigar	417-681-5100	19,688
Bell Memorial Hospital	MI	Richard Ament	906-486-4431	24,722
Bertie Memorial Hospital	NC	Jeff Sackrison	252-794-6600	12,456
Booneville Community Hospital	AR	Dzaidi Daud	479-675-2800	11,243
Bridgton Hospital	ME	David Frum	207-647-6000	33,665
Bucyrus Community Hospital	OH	Scott Landrum	419-562-4677	21,796
Caldwell Medical Center	KY	Charles Lovell	270-365-0300	19,183
Carilion Giles Community Hospital	VA	James Tyler	540-266-6000	26,700
Casey County Hospital	KY	Rex Tungate	606-787-6275	13,423
Cass Regional Medical Center	MO	Chris Lang	816-380-3474	28,112
Chatham Hospital	NC	Carol Straight	919-799-4000	25,570
Chippewa County-Montevideo Hospital & Medical Clinic	MN	Mark Paulson	320-269-8877	12,409
Clark Fork Valley Hospital	MT	Gregory Hanson	406-826-4800	10,238
Clinch Memorial Hospital	GA	Phillip Cook	912-487-5211	7,712
Community Hospital of Bremen	IN	Scott Graybill	574-546-2211	10,663
Community Medical Center	NE	Ryan Larsen	402-245-2428	8,271
Community Memorial Hospital	OH	Mel Fahs	419-542-6692	13,131
Cottage Grove Community Hospital	OR	Mary Anne McMurren	541-942-0511	18,988
Crete Area Medical Center	NE	Carol Friesen	402-826-2102	11,294
Delta Memorial Hospital	AR	Cris Bolin	870-382-4303	11,146
Doctor's Memorial Hospital	FL	Jo Ann Baker	850-547-8000	19,582
Drumright Regional Hospital	OK	Darrel Morris	918-382-2300	5,958
Ellsworth County Medical Center	KS	Roger Masse	785-472-3111	11,201
Fall River Health Service	SD	Tricia Uhlir	605-745-3159	8,008
Family Health West	CO	Errol Snider	970-858-9871	12,236
Faulkton Area Medical Hospital	SD	Jay Jahnig	605-598-6262	2,407
Fort Logan Hospital	KY	Mike Jackson	606-365-4600	27,537
Franklin Foundation Hospital	LA	Parker Templeton	337-828-0760	17,424
Fulton County Medical Center	PA	Jason Hawkins	717-485-3155	21,439
Grand River Hospital and Medical Center	CO	Jim Coombs	970-625-1510	25,576
Harney District Hospital	OR	Jim Bishop	541-573-7281	6,888
Harrison County Hospital	IN	Steve Taylor	812-738-4251	40,895
Hayward Area Memorial Hospital	WI	Tim Gullingsrud	715-934-4321	18,955
Heart of the Rockies RMC	CO	Ken Leisher	719-530-2210	22,501
Hermann Area District Hospital	MO	Dan McKinney	573-486-2191	7,832
Holton Community Hospital	KS	Ron Marshall	785-364-2116	10,302
Hospital "A", U.S.A.	-	-	-	36,861
Hospital "B", U.S.A. calais	-	-	-	13,532
Hudson Hospital & Clinics	WI	Marian Furlong	715-531-6000	35,763
Indiana University Health Blackford Hospital	IN	Steven West	765-348-0300	19,050
Indiana University White County Memorial Hospital	IN	Stephanie Long	574-583-7111	19,891
Iraan General Hospital	TX	Teresa Callahan	432-639-2575	1,799
Jefferson County Health Center	IA	Deb Cardin	641-472-4111	20,781
Jersey Shore Hospital	PA	Carey Plummer	570-398-0100	34,508
Jones Regional Medical Center	IA	Eric Briesemeister	319-462-6131	19,688
Keokuk County Health Center	IA	Ray Brownsworth	641-622-2720	3,564
Kewanee Hospital	IL	Margaret Gustafson	309-852-7500	25,010
Kingfisher Regional Hospital	OK	Nancy Schmid	405-375-3141	11,250
Kit Carson County Memorial Hospital	CO	Joe Stratton	719-346-5311	9,034
LakeWood Health Center	MN	Jason Breuer	218-634-2120	4,490

FACILITY NAME	STATE	ADMIN/CEO	TEL	POP
Lakewood Health System Hospital	MN	Tim Rice	218-894-1515	20,106
Limestone Medical Center	TX	Penny Gray	254-729-3281	9,339
Madison Valley Medical Center	MT	Loren Jacobson	406-682-6862	6,064
Marshall County Hospital	KY	Kathy Long	270-527-4800	27,417
McCune-Brooks Regional Hospital	MO	Bob Copeland	417-358-8121	32,978
Meade District Hospital	KS	Mickey Thomas	620-873-2141	8,005
Melissa Memorial Hospital	CO	John Ayoub	970-854-2241	3,037
Memorial Hospital	IL	Ada Bair	217-357-8500	14,797
Midwest Medical Center	IL	Tracy Bauer	815-777-1340	7,845
Mitchell County Hospital	TX	Robbie Dewberry	325-728-3431	10,700
Moloka`i General Hospital	HI	Janice Kalanihuia	808-553-5331	5,680
Morton General Hospital	WA	Ron DeArth	360-496-3537	11,451
Mountainview Medical Center	MT	Aaron Rogers	406-547-3321	1,923
Mountrail County Medical Center	ND	Rick Wittmeier	701-628-2424	2,224
Munising Memorial Hospital	MI	Kevin Calhoun	906-387-4110	6,489
North Canyon Medical Center	ID	David Butler	208-934-4433	20,618
North Valley Hospital	MT	Jason Spring	406-863-3500	34,258
Oakes Community Hospital	ND	Lee Boyles	701-742-3291	11,632
Okeene Municipal Hospital	OK	Shelly Dunham	580-822-4417	5,671
Orange City Municipal Hospital	IA	Martin Guthmiller	712-737-4984	12,843
Osceola Medical Center	WI	Jeffrey Meyer	715-294-2111	11,836
Our Lady of Victory Hospital	WI	Cynthia Eichman	715-644-6144	13,508
Ozark Health Medical Center	AR	Kirk Reamey	501-745-7000	22,142
Parkview LaGrange Hospital	IN	Rob Myers	260-463-9000	35,826
Parmer Medical Center	TX	Lance Gatlin	806-250-2754	7,381
Phillips County Hospital & Family Health Clinic	MT	Ward Van Wichen	406-654-1100	3,825
Potomac Valley Hospital	WV	Linda Shroyer	304-597-3500	20,815
Providence Mount Carmel Hospital	WA	Bob Campbell	509-685-5100	25,461
Providence Valdez Medical Center	AK	Sean McAllister	907-835-2249	4,121
Pullman Regional Hospital	WA	Scott Adams	509-332-2541	36,739
Ringgold County Hospital	IA	Gordon Winkler	641-464-3226	6,346
Rio Grande Hospital	CO	Arlene Harms	719-657-2510	18,002
River's Edge Hospital & Clinic	MN	Colleen Spike	507-931-2200	15,372
Riverwood Healthcare Center	MN	Michael Hagen	218-927-2121	14,494
Rooks County Health Center	KS	Michael Sinclair	785-434-4553	5,314
Sacred Heart Hospital	WI	Monica Hilt	715-453-7700	12,679
Sanford Luverne Medical Center	MN	Tammy Loosbrock	207-283-2321	11,700
Saunders Medical Center	NE	Ken Archer	402-443-4191	7,580
Scheurer Hospital	MI	Dwight Gascho	989-453-3223	12,781
Shoshone Medical Center	ID	Gary Moore	208-784-1221	12,113
Southern Coos Hospital & Health Center	OR	James Wathen	541-329-1031	10,148
Southwest Health Center	WI	Don Rohrbach	608-348-2331	27,731
St. James Medical Center - Mayo Health System	MN	Scott Thoreson	507-375-3391	9,108
St. James Parish Hospital	LA	Mary Ellen Pratt	225-746-2990	15,217
St. Vincent Randolph Hospital	IN	Cheech Albarano	765-584-0004	18,383
Steele Memorial Medical Center	ID	Jeff Hill	208-756-5600	10,492
Story County Medical Center	IA	Todd Willert	515-382-2111	10,910
The Memorial Hospital	CO	George Rohrich	970-824-9411	17,349
Tomah Memorial Hospital	WI	Philip Stuart	608-372-2181	22,840
Tri-Valley Health / Cambridge Memorial Hospital	NE	Roger Steinkruger	308-697-1124	5,150
Wallowa Memorial Hospital	OR	David Harman	541-426-3111	6,962
Washington County Hospital and Clinics	IA	Dennis Hunger	319-653-5481	20,587
Weatherford Regional Hospital	OK	Debbie Howe	580-772-5551	22,897
West River Health Services	ND	Jim Long	701-567-4561	14,562
Wilson Medical Center	KS	Dennis Shelby	620-325-2611	4,385
Winkler County Memorial Hospital	TX	Bill Ernst	432-586-8299	6,947
Yuma District Hospital and Clinics	CO	John Gardner	970-848-5405	9,302

Population is defined as the sum total of populations in all ZIP codes in which the hospital had at least 10% market share of 2010 Medicare admissions.



prepared and sponsored by STROUDWATER ASSOCIATES

sponsored by DOUGHERTY MORTGAGE LLC

NEENAN architstruction®

PHOTOS: TOP, CARILLON OILES COMMUNITY HOSPITAL, PEARISBURG, VA; BOTTOM LEFT, KIT CARSON COUNTY MEMORIAL HOSPITAL, BURLINGTON, CO; BOTTOM RIGHT, PROVIDENCE VALDEZ MEDICAL CENTER, VALDEZ, AK

Stroudwater Associates
50 Sewall Street, Suite 102
Portland, ME 04102
800.947.5712
www.stroudwater.com

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 10

Section C, Economic Feasibility, Item 1

Project Cost Documentation

Sum

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

JE DUNN CONSTRUCTION

Construction Cost Summary

Description	Quantity	Cost	Unit Cost
Sitework	150 Cars	1,290,053	8,575
1 Story Hospital	37,611 SF	11,131,829	295.97
1 Story Medical Building	9,241 SF	1,892,453	204.79
Construction Subtotal	46,852 SF	14,314,335	$305.52
Design Fees & Reimbursables	8%	1,145,147	24.44
Design Contingency	4%	618,379	13.20
Construction Contingency	4%	572,573	12.22
Escalation to 3rd Qtr 2016	6%	999,026	21.32
Total Construction Cost	**46,852 SF**	**$17,649,461**	**$376.71**

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

Sitework

Item	Description	Cost
1	General Requirements	86,434
2	Excavation and Grading	409,337
3	Asphalt Paving	162,944
4	Concrete Work	77,221
5	Site Structures	0
6	Fencing	0
7	Specialty Paving	20,149
8	Signage and Striping	16,555
9	Site Specialties	29,292
10	Site Utilities	40,992
11	Storm Drainage Systems	66,517
12	Fire Protection	51,059
13	Landscaping and Irrigation	89,551
14	Electrical	141,160
	Subtotal	1,191,210
	Permits, Bonds and Insurance	37,412
	Contingency	0
	Escalation	0
	Fee	61,431
	Total	**$1,290,053**

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

1 Story Hospital
37,611 SF

Item	Description	Cost	Cost/SF
1	General Requirements	745,833	19.83
2	Excavation	96,694	2.57
3	Building Structure	910,847	24.22
4	Building Skin	260,933	6.94
5	Interior Masonry	0	0.00
6	Rough Carpentry	111,573	2.97
7	Finish Carpentry and Millwork	421,577	11.21
8	Membrane Roofing	260,191	6.92
9	Sheet Metal	47,920	1.27
10	Caulking and Dampproofing	63,955	1.70
11	Doors, Frames and Hardware	363,287	9.66
12	Glass and Glazing Systems	244,366	6.50
13	Plaster and Drywall Systems	707,790	18.82
14	Stone and Tile	44,836	1.19
15	Ceilings	169,738	4.51
16	Flooring	235,502	6.26
17	Painting	80,869	2.15
18	Specialties	175,425	4.66
19	Equipment and Furnishings	167,158	4.44
20	Special Construction	67,005	1.78
21	Elevators	0	0.00
22	Fire Protection	6,765	0.18
23	Plumbing	1,483,853	39.45
24	HVAC Systems	2,047,123	54.43
25	Electrical	1,565,678	41.63
	Subtotal	10,278,919	273.30
	Permits, Bonds and Insurance	322,823	8.58
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	530,087	14.09
	Total	**$11,131,829**	**$295.97**

Skin/Floor Area Ratio	41%	Total Skin Cost, Contact Area	$46.50 /SF
Glass/Skin Area Ratio	23%	Skin Cost, Bldg Area	$13.43 /SF

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

1 Story Medical Building
9,241 SF

Item	Description	Cost	Cost/SF
1	General Requirements	126,794	13.72
2	Excavation	26,315	2.85
3	Building Structure	233,552	25.27
4	Building Skin	63,703	6.89
5	Interior Masonry	0	0.00
6	Rough Carpentry	29,658	3.21
7	Finish Carpentry and Millwork	102,366	11.08
8	Membrane Roofing	78,658	8.51
9	Sheet Metal	10,827	1.17
10	Caulking and Dampproofing	14,719	1.59
11	Doors, Frames and Hardware	98,289	10.64
12	Glass and Glazing Systems	51,700	5.59
13	Plaster and Drywall Systems	180,436	19.53
14	Ceramic Tile	0	0.00
15	Ceilings	43,229	4.68
16	Flooring	47,334	5.12
17	Painting	20,411	2.21
18	Specialties	15,016	1.62
19	Equipment and Furnishings	5,956	0.64
20	Special Construction	0	0.00
21	Elevators	0	0.00
22	Fire Protection	27,535	2.98
23	Plumbing	158,085	17.11
24	HVAC Systems	189,702	20.53
25	Electrical	223,170	24.15
	Subtotal	1,747,455	189.10
	Permits, Bonds and Insurance	54,881	5.94
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	90,117	9.75
	Total	**$1,892,453**	**$204.79**

Skin/Floor Area Ratio	38%	Total Skin Cost, Contact Area	$48.93 /SF
Glass/Skin Area Ratio	14%	Skin Cost, Bldg Area	$12.49 /SF

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 11

Section C, Economic Feasibility, Item 2

Funding Documentation

Attachment 11
Section C, Economic Feasibility, Item 2
Funding Documentation

CHHS
Community Hospitality Healthcare Services

January 8th, 2016

Jim Shaffer, President
CAH Acquisition Company 11, LLC
d/b/a Lauderdale Community Hospital
1100 Main, Suite 2350
Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,
Community Hospitality Healthcare Services has received an array of information regarding the proposed replacement of the Lauderdale Hospital facility located in Ripley, Tennessee. As a federally certified "Community Development Entity" (CDE) by the CDFI Fund at the US Treasury with a national footprint, we would be interested in providing a sub-allocation of New Markets Tax Credits to the project. With a focus on healthcare infrastructure and job creation in distressed communities, we have funded dozens of projects with similar attributes. The project is located in a highly qualified census tract within a rural community. Based upon the geography and initial estimates of community impacts, including creation of quality jobs and services provided to the community, the project meets our initial thresholds for underwriting. Receipt of final NMTC investment from CHHS is contingent upon:

-Obtaining all necessary entitlements and approvals required by law, including Certificates of Need;
-Securing first-lien debt and additional capital sources required to fully fund the project;
-Collection of additional transaction diligence items;
-Availability of allocation at the time the project is ready to commence closing process; and
-Final underwriting and approval.

We anticipate that the NMTC investment will provide up to 23% of the capital required to complete the project, in the form of a subordinated interest-only note with a term of no less than 7 years at an interest rate in the 2.5-3% range. We look forward to working with you on this highly impactful project.

Sincerely,

Benjamin Cirka
Executive Director
Community Hospitality Healthcare Services

CFG CAPITAL MARKETS, LLC
MEMBER FINRA/SIPC

January 8, 2016

Jim Shaffer, President
CAH Acquisition Company 11 LLC
d/b/a, Lauderdale Community Hospital
1100 Main, Suite 2350
Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,

CFG Capital Markets, LLC, ("CFGCM") appreciates the opportunity to work with you on the proposed $23,000,000 replacement of the Lauderdale Community Hospital in Ripley, Tennessee. This letter confirms our engagement to facilitate the development of the replacement facility including identifying commercial banks to provide construction financing based on current markets conditions. Based on our discussions with lending sources to date, we believe there is debt financing available for the development of the replacement facility.

We believe lending institutions will provide up to 75% of project costs with the New Market Tax Credits and equity accounting for the balance. The terms of the debt will depend on the institution providing the loan, but should generally reflect a seven-year term to mirror the New Market Tax Credit component and the interest rate should generally range between LIBOR plus 350 to 450.

The commitment to provide the debt financing will be subject to customary underwriting and due diligence of the lender, including, but not limited to:

- Obtaining all necessary entitlements and approvals, including the Certificate of Need;
- Third party reports;
- Lender site visit; and
- Lender underwriting criteria.

We, and the initial lenders we have spoken to, believe this project is highly desirable based on the performance of the current facility.

CFGCM is not itself a lending institution, but based on our deep ties in the lending community for healthcare facilities, we believe the debt financing can be obtained. We look forward to working with you and your team to assist you with the development of this replacement Critical Access Hospital.

Sincerely,

Samer S. Tahboub
Director
CFG Capital Markets, LLC

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 12

Section C, Economic Feasibility, Item 6A

Medicare Rate Letters

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Attachment 12
Section C, Economic Feasibility, Item 6A
LCH Medicare rate letters

March 13, 2015

Medicare Interim Rate Review Summary

Provider Number	441314	Provider Name	CAH ACQUISITION COMPANY 11 LLC
Rate Review Period Ended	03/12/2015	Cost Reporting Period	09/30/2015
Target Completion Date	03/12/2015	Actual Completion Date	03/12/2015

Your revised rates and effective dates are listed below. Blank indicates rate is not being changed or is not applicable to your facility.

PIP Biweekly Rate		Effective:	
Pass Through Biweekly Rate		Effective:	

Pass Through Breakdown

	Part A	Part B	Total
Bad Debts			
GME/Allied Health			
CRNA			
Organ Acquisition			
Other			
Total:			

Operating Intern to Bed		Effective:	
Medicaid Ratio		Effective:	
Per Diem	$1,875.00	Effective:	03/15/2015
Outpatient Percentage	0.33	Effective:	03/15/2015
Rural Health Rate		Effective:	
Other (Describe)		Effective:	

Lump Sum Payment Due Provider/(Program):

Part A	Part B	Total
$0.00	$0.00	$0.00

If total is positive, the amount due provider will be applied to any outstanding overpayments as noted below. The remaining balance will be included in your remittance within 15 days of this notice.

If the total is negative, please refer to letter titled "First Request for Payment of Lump Sum Adjustment" for repayment instructions.

Invoice Description Invoice Amount Remaining Balance

Completed By:	B15476	Date:	03/12/2015
Approved By:	B9718	Date:	03/12/2015

Work Object ID: IR-25787
Workload Number: 10301
PTAN: 441314
NPI: 1932421401

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

March 13, 2015

Medicare Interim Rate Review Summary

Provider Number	44Z314	Provider Name	CAH ACQUISITION COMPANY 11 LLC
Rate Review Period Ended	03/12/2015	Cost Reporting Period	09/30/2015
Target Completion Date	03/12/2015	Actual Completion Date	03/12/2015

Your revised rates and effective dates are listed below. Blank indicates rate is not being changed or is not applicable to your facility.

PIP Biweekly Rate — Effective:
Pass Through Biweekly Rate — Effective:

Pass Through Breakdown

	Part A	Part B	Total
Bad Debts			
GME/Allied Health			
CRNA			
Organ Acquisition			
Other			
Total:			

Operating Intern to Bed		Effective:	
Medicaid Ratio		Effective:	
Per Diem	$1,580.00	Effective:	03/15/2015
Outpatient Percentage		Effective:	
Rural Health Rate		Effective:	
Other (Describe)		Effective:	

Lump Sum Payment Due Provider/(Program):

Part A	Part B	Total
$0.00	$0.00	$0.00

If total is positive, the amount due provider will be applied to any outstanding overpayments as noted below. The remaining balance will be included in your remittance within 15 days of this notice.

If the total is negative, please refer to letter titled "First Request for Payment of Lump Sum Adjustment" for repayment instructions.

Invoice Description Invoice Amount Remaining Balance

Completed By: B15476 — Date: 03/12/2015
Approved By: B9718 — Date: 03/12/2015

Work Object ID: IR-25788
Workload Number: 10301
PTAN: 44Z314
NPI: 1962725242

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT
SUITE 1500
JAMES K. POLK STATE OFFICE BUILDING
NASHVILLE, TENNESSEE 37243-0264
PHONE (615) 401-7897
FAX (615) 532-2765

September 24, 2015

Mr. Scott Tongate
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

Re: Critical Access Hospital Revised Rate
Provider No: 044-1314

Dear Mr. Tongate:

We have computed new interim supplemental reimbursement rates for your facility. The data used to calculate these rates come from your Joint Annual Report filed with the state for the fiscal year ended September 30, 2013. Your facility will be reimbursed quarterly through these revised rates.

The new interim rates for your facility, effective for dates of service on and after July 1, 2015, are:

Inpatient Services	$ 437.79
Outpatient Services	20.14 % of charges

If you have any questions concerning the interim rate calculation, please contact Karen Degges at (615) 747-5203 or by e-mail at Karen.Degges@cot.tn.gov.

Sincerely,

Gregg S. Hawkins KD

Gregg S. Hawkins, CPA
Assistant Director

cc: William Aaron, Bureau of TennCare

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 13

Section C, Economic Feasibility, Item 9

Most Current Financial Statements and most recent Audited Financials

Lauderdale Community Hospital
Income Statement- Current Month to Prior Month Comparison
For the Period ended, November 30, 2015

November-15						YTD		
Actual	Prior Month	Var	Prior Year	Var		Actual	Prior Year	Var
					Patient Revenue:			
828,570	577,804	43.4%	503,959	64.4%	Inpatient Services	1,406,374	893,557	57.4%
2,997,859	3,211,049	-6.6%	2,683,910	11.7%	Outpatient Services	6,208,908	5,490,384	13.1%
-	-	#DIV/0!	205	-100.0%	Clinic Services/Professional Fees	-	6,449	-100.0%
3,826,429	**3,788,854**	**1.0%**	**3,188,074**	**20.0%**	**Total Patient Revenue**	**7,615,282**	**6,390,390**	**19.2%**
2,729,982	**2,785,808**	**-2.0%**	**2,072,664**	**31.7%**	**Total Deductions From Revenue**	**5,515,790**	**4,093,757**	**34.7%**
1,096,447	**1,003,045**	**9.3%**	**1,115,411**	**-1.7%**	**Net Patient Services Revenue**	**2,099,492**	**2,296,633**	**-8.6%**
28.65%	26.47%		34.99%		Realization %	27.57%	35.94%	
27,122	-	#DIV/0!	138,853	-80.5%	Other Revenue	58,978	172,217	-65.8%
1,123,569	**1,003,045**	**12.0%**	**1,254,264**	**-10.4%**	**Total Operating Revenues**	**2,158,470**	**2,468,850**	**-12.6%**
					Operating Expenses:			
436,380	98,951	341.0%	570,186	-23.5%	Salaries and Wages	894,264	1,162,303	-23.1%
101,268	99,927	1.3%	120,832	-16.2%	Benefits	200,219	231,032	-13.3%
70,797	57,820	22.4%	84,995	-16.7%	Supplies	170,724	185,390	-7.9%
58,820	59,911	-1.8%	57,570	2.2%	Medical Specialist Fees	116,639	112,889	3.3%
82,546	118,333	-30.2%	100,412	-17.8%	Purchased Services	142,456	163,236	-12.7%
118,333	98,455	20.2%	118,333	0.0%	Management Fees	236,666	236,666	0.0%
99,416	-	#DIV/0!	103,835	-4.3%	Other Operating Expenses	197,871	212,122	-6.7%
967,559	**533,396**	**81.4%**	**1,156,162**	**-16.3%**	**Total Operating Expenses**	**1,958,839**	**2,303,638**	**-15.0%**
156,010	**469,650**	**-66.8%**	**98,101**	**59.0%**	**E.B.I.T.D.A.**	**199,631**	**165,212**	**20.8%**
-	(57,824)	-100.0%	-	#DIV/0!	Extraordinary Items	-	-	#DIV/0!
(57,649)	(33,191)	73.7%	(71,716)	-19.6%	Depreciation and Amortization	(115,474)	(143,431)	-19.5%
(25,654)	0	-6933740.5%	(28,995)	-11.5%	Interest Expense	(58,845)	(61,023)	-3.6%
-	-	#DIV/0!	6	-100.0%	Interest Income	0	6	-93.7%
72,706	**378,635**	**-80.8%**	**(2,603)**	**-2893.3%**	**Net Income Before Taxes**	**25,312**	**(39,237)**	**-164.5%**

Balance Sheet	Oct-15	Nov-15
ASSETS		
Current Assets:		
Cash and cash equivalents	51,457	18,222
Patient accounts receivable	9,600,868	9,857,394
Less: Reserves for Uncollectible	(6,288,204)	(6,510,061)
Home Office Settlement		
Supplies	194,594	188,109
Prepaid expenses	452,311	418,397
Third-Party Settlement	1,695,435	934,743
Other current assets	141,253	131,054
Total Current Assets	**5,847,715**	**5,037,859**
Property & Equipment, at cost:		
Construction in Progress	42,150	42,150
Land and improvements	127,359	127,359
Buildings and improvements	3,524,189	3,524,189
Equipment and fixtures	2,335,725	2,335,725
Total PP&E	6,029,423	6,029,423
Less accumulated depreciation	(4,958,833)	(5,016,482)
and amortization		
Net Property and Equipment	**1,070,591**	**1,012,941**
Other Assets:		
Investments	-	-
Goodwill	-	-
Restricted Cash	-	-
Other	329,249	329,249
Total Other Assets	**329,249**	**329,249**
Total Assets	**7,247,555**	**6,380,049**

	Oct-15	Nov-15
LIABILITIES		
Current Liabilities:		
Current maturities of LTD	571,302	510,258
Accounts payable	1,644,216	1,540,676
Cure Payable	50,179	50,179
Due/(From) HMC	(3,130,272)	(4,142,414)
Accrued Liabilities	1,554,042	1,571,457
Other Current Liabilities	878,872	904,868
Total Current Liabilities	**1,568,339**	**435,025**
Long-Term Debt	3,958,642	4,157,827
Deferred Revenue	139,903	133,821
Stockholders' Equity:		
Members Equity	567,380	567,380
Retained Earnings	1,060,684	1,060,684
Net Income	(47,394)	25,312
Total Stockholders' Equity	**1,580,670**	**1,653,376**
Total Liabilities and Stockholders Equity	**7,247,555**	**6,380,049**

HMC/CAH Consolidated, Inc.

HMC/CAH CONSOLIDATED, INC.

Consolidated Financial Report and Supplemental Information

September 30, 2014

Arnett Carbis Toothman llp
CPAs & Advisors

CONTENTS

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors
HMC/CAH Consolidated, Inc.
Kansas City, Missouri

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of HMC/CAH Consolidated, Inc. which comprise the balance sheet as of September 30, 2014, and the related consolidated statements of operations, stockholders' equity (deficit) and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above presents fairly, in all material respects, the financial position of HMC/CAH Consolidated, Inc. as of September 30, 2014, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

Reorganization Proceedings under Chapter 11 of the United States Bankruptcy Code

As discussed in Note 1 to the consolidated financial statements, on October 10, 2011, the Corporation filed a voluntary petition for reorganization under Chapter 11 of the United States Bankruptcy Code. On December 12, 2012, the Bankruptcy Court entered an order confirming the plan of reorganization, which became effective on January 17, 2013.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated balance sheet as a whole. The consolidating information is presented for purposes of additional analysis rather than to present the financial position, results of operations, and cash flows of the individual companies and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Arnett Carbis Toothman LLP

Charleston, West Virginia
June 5, 2015

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED BALANCE SHEET
September 30, 2014

ASSETS	
Current assets	
Cash and cash equivalents	$ 1,349,802
Patient accounts receivable, net of estimated uncollectibles of $13,008,000	12,913,137
Inventory of supplies	2,070,845
Prepaid expenses	2,424,146
Other receivables	56,117
Total current assets	18,814,047
Property and equipment, net	23,335,735
Assets Limited as to use	1,145,088
Other assets	
Deferred financing cost, net	786,474
Total assets	$ 44,081,344
LIABILITIES AND STOCKHOLDERS' EQUITY (DEFICIT)	
Current liabilities	
Current installments of long-term debt	$ 4,747,871
Deferred revenue – current portion	954,001
Accounts payable	11,567,034
Reorganization obligations current portion	1,793,640
Estimated third-party payor settlements	1,227,000
Accrued expenses	7,537,346
Total current liabilities	27,826,892
Long-term debt, excluding current portion	38,390,294
Reorganization obligations, excluding current portion	1,259,196
Estimated third-party payor settlements	3,732,389
Deferred revenue	3,076,613
Total liabilities	74,285,384
Stockholders' equity (deficit)	(30,204,040)
Total liabilities and stockholders' equity (deficit)	$ 44,081,344

See accompanying notes to consolidated financial statements

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED STATEMENT OF OPERATIONS
Year Ended September 30, 2014

Revenues	
Patient service revenue (net of contractual allowances and discounts)	$ 104,178,383
Provision for bad debts	(15,757,181)
Net patient service revenue less provision for bad debts	88,421,202
Other operating revenue	1,450,344
Electronic health record incentive reimbursement	755,301
Total revenues	90,626,847
Expenses	
Salaries and wages	42,934,730
Payroll taxes and benefits	7,850,655
Supplies and other	16,339,274
Medical professionals	3,226,316
Purchased services	8,194,122
Management fees	9,751,498
Depreciation and amortization	4,237,758
Interest expense	3,282,378
Total expenses	95,816,731
Operating loss	(5,189,884)
Non-operating income	
Investment income	58,651
Net loss	$ (5,131,233)

See accompanying notes to consolidated financial statements

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
Year Ended September 30, 2014

	Retained Earnings (Deficit)	Preferred Capital Stock		Common Capital Stock		Total Stockholders' Equity (Deficit)
		Par Value	Additional Paid In Capital	Par Value	Additional Paid In Capital	
BALANCE, SEPTEMBER 30, 2013	$ (49,020,560)	$ 189	$ 22,656,672	$ 290,892	$ 1,000,000	$ (25,072,807)
Net loss	(5,131,233)	-	-	-	-	(5,131,233)
BALANCE, SEPTEMBER 30, 2014	$ (54,151,793)	$ 189	$ 22,656,672	$ 290,892	$ 1,000,000	$ (30,204,040)

See accompanying notes to consolidated financial statements

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED STATEMENT OF CASH FLOWS
Year Ended September 30, 2014

Cash flows from operating activities	
Net loss	$ (5,131,233)
Adjustments to reconcile net loss to net cash used in operating activities:	
Depreciation and amortization	4,237,758
Provision for bad debts	15,757,181
Loss on sale of property and equipment	9,456
(Increase) decrease in:	
Patient accounts receivable	(20,032,954)
Inventory of supplies	31,311
Prepaid expenses	(163,311)
Other receivables	1,610,342
Increase (decrease) in:	
Accounts payable and accrued expenses	1,577,152
Third-party payor settlements	1,142,084
Deferred revenue	(933,984)
Net cash used in operating activities	(1,896,198)
Cash flows from investing activities	
Purchase of property and equipment	(836,758)
Proceeds from sale of property and equipment	145,000
Change in assets whose use is limited, net	(320,623)
Net cash used in investing activities	(1,012,381)
Cash flows from financing activities	
Principal payments on long-term debt	(5,304,821)
Proceeds from the issuance of long-term debt	10,170,000
Payment on reorganization liabilities	(807,602)
Deferred financing costs	(582,776)
Net cash provided by financing activities	3,474,801
Net increase in cash and cash equivalents	566,222
Cash and cash equivalents, beginning of year	783,580
Cash and cash equivalents, end of year	$ 1,349,802
Supplemental disclosure of noncash financing and investing activities	
Cash paid for interest	$ 3,282,378
Capital lease obligations incurred for equipment	$ 1,665,412
Long-term debt obligations incurred for property and equipment	$ 770,000

See accompanying notes to consolidated financial statements

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 1. Summary of Significant Accounting Policies

Description of Business Organization

HMC/CAH Consolidated, Inc. (HMC) was incorporated on May 15, 2007 in the state of Delaware and was capitalized on May 31, 2007 through a combination of Common Stock, Series A Preferred Stock and Short-Term Debt issuances.

HMC is in the business of acquiring and operating acute care hospitals located in rural communities that are certified as critical access hospitals (CAHs) by the Center for Medicare and Medicaid Services (CMS). HMC plans to replace the existing medical facilities of the CAHs it acquires with newly-constructed medical facilities.

HMC conducts its business through a consolidated group of wholly-owned subsidiaries (HMC Hospitals). HMC and the HMC Hospitals are hereinafter referred collectively as the "Corporation." Since commencing business on May 31, 2007, the Corporation has purchased the business and assets of twelve CAHs, all of which for the year ending September 30, 2014 were in operation. The CAHs that HMC has acquired are as following:

1. CAH Acquisition Company #1, LLC (CAH1) - June 1, 2007 - Washington County Community Hospital, Plymouth, North Carolina.

2. CAH Acquisition Company #2, LLC (CAH2) - October 1, 2007 - Oswego Community Hospital, Oswego, Kansas.

3. CAH Acquisition Company #3, LLC (CAH3) - January 1, 2008 - Horton Community Hospital, Horton, Kansas.

4. CAH Acquisition Company #5, LLC (CAH5) - September 1, 2008 - Hillsboro Community Hospital, Hillsboro, Kansas.

5. CAH Acquisition Company #7, LLC (CAH7) - December 1, 2008 - Prague Community Hospital, Prague, Oklahoma.

6. CAH Acquisition Company #6, LLC (CAH6) - March 1, 2009 - I-70 Community Hospital, Sweet Springs, Missouri.

7. CAH Acquisition Company #4, Inc. (CAH4) - April 1, 2009 - Drumright Regional Hospital, a CAH located in Drumright, Oklahoma.

8. CAH Acquisition Company #9, LLC (CAH9) - July 1, 2009 - Seiling Community Hospital, Seiling, Oklahoma.

9. CAH Acquisition Company #12, LLC (CAH12) - February 1, 2010 - Fairfax Community Hospital, Fairfax, Oklahoma.

10. CAH Acquisition Company #11, LLC (CAH11) - April 1, 2010 - Lauderdale Community Hospital, Ripley, Tennessee.

11. CAH Acquisition Company #10, LLC (CAH10) - May 1, 2010 - Yadkin Valley Community Hospital, Yadkinville, North Carolina.

12. CAH Acquisition Company #16, LLC (CAH16) - August 1, 2010 - Haskell County Community Hospital, Stigler, Oklahoma.

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Plan of Reorganization (the "Plan")

HMC/CAH Consolidated, Inc. (HMC) and its twelve critical access hospital subsidiaries (HMC Hospitals) were HMC/CAH and debtors-in-possession (collectively, Debtors) in Chapter 11 proceedings filed on October 10, 2011 in the United States Bankruptcy Court for the Western District of Missouri.

On September 7, 2012, HMC/CAH proposed a Plan to the court and the creditors. The Plan was structured so that secured creditors would receive full payment of their principal balances, except for secured creditor HPGC Hospital Investments, LLC (HHI). The proposed Plan gave unsecured creditors the option to take either an immediate discounted payment of their claims (the Discount Option), or full payment over a period of eleven years at a 2% interest rate (the 100% Option).

In December 2010 creditor HHI (after funding $15 million of its $31 million commitment) defaulted on its loan agreement with HMC/CAH. HMC/CAH filed suit against HHI and after the Chapter 11 proceeding was filed in October 2011; this litigation provided HMC/CAH with a legal basis to dispute HHI's $15 million secured claim. Prior to the voting on the Plan, HMC/CAH and HHI reached a settlement whereby HHI, in exchange for its agreement to reduce its secured claim to $5 million, was given a $10 million preferred equity interest in HMC/CAH.

On November 12, 2012, the Plan was put to a vote. All of the eligible secured creditor classes and the required number of unsecured creditors voted to accept the Plan. The total dollar amount of the unsecured claims was approximately $7 million; and of that amount, approximate $2 million elected the 100% Option and $5 million elected the Discount Option.

At the December 12, 2012 confirmation hearing the court entered its order confirming the Joint Plan (Confirmation Order) which became final for purposes of appeal on December 26, 2012. Approximately $4 million in cash was needed by HMC/CAH to fund their exit from the Chapter 11 proceeding. The Plan contemplated, and the Confirmation Order authorized, HMC/CAH to enter into a Management Rights Sale transaction in order to raise this cash. Thereafter, on January 17, 2013, the Management Rights Sale (Note 22) closed and HMC/CAH filed their notice of the effective date of the Plan.

Implementation of the Plan

Subsequent to the January 17, 2013 effective date, the provisions of the Plan were implemented as follows:

1. HMC/CAH used the $4 million of sales proceeds to fund the "pots" of money at the HMC Hospitals in the aggregate amount of approximately $1 million to make the pro rata payments to the unsecured creditors who elected the Discount Option;

2. HMC/CAH used the $3 million of sales proceeds remaining to pay all other accumulated reorganization costs

3. The capital structure of HMC and the secured lender terms and lien priorities of HMC/CAH were reorganized. (Note 10)

Principles of Consolidation: The consolidated financial statements include the accounts of HMC/CAH Consolidated, Inc. and its subsidiaries (collectively referred to as the Corporation in the accompanying footnotes). All significant intercompany balances and transactions are eliminated in consolidation.

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Use of Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents are highly liquid interest-bearing bank deposits and repurchase agreements. The carrying amount of cash and cash equivalents approximates fair market value. For purposes of the statement of cash flows, the Corporation considers all highly liquid financial instruments purchased with an original maturity of three months or less to be cash equivalents.

Patient Accounts Receivable: Patient accounts receivable are carried at the original charge less an estimate made for doubtful or uncollectible accounts. In evaluating the collectability of accounts receivable, the Corporation analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. The allowance is based upon a review of the outstanding balances aged by financial class. Management uses collection percentages based upon historical collection experience to determine collectability. Management also reviews troubled, aged accounts to determine collection potential. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third–party coverage exists for part of the bill), the Corporation records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. Recoveries of accounts previously written off are recorded as a reduction to bad debt expense when received. Interest is not charged on patient accounts.

The Corporation's allowance for doubtful accounts for self-pay patients was 89 percent of self-pay accounts receivable at September 30, 2014. In addition, the Corporation's self-pay write offs were approximately $6.3 million for fiscal year 2014. The Corporation's uninsured discount policy is 30% for patients with no third-party coverage and who did not qualify for charity care. The Corporation does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write offs from third-party payors.

Inventory of Supplies: The inventory of supplies is maintained on a first-in, first-out basis and is stated at the lower of cost or market.

Property and Equipment: Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

	Years
Buildings and improvements (including those under capital and financing leases)	10 – 40
Equipment	3 – 10
Equipment under capital leases	3 – 5

Deferred Financing Costs: Deferred financing costs are amortized over the period the obligation is outstanding using the straight-line method, which is not materially different than the effective interest method. Amortization expense related to the deferred financing costs was $46,128 for the year ended September 30, 2014.

Net Patient Service Revenue: The Corporation has agreements with third-party payors that provide for payments at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Income Taxes: The Corporation provides for income taxes in accordance with financial accounting standards, which requires the asset and liability approach be used to determine deferred income taxes. Deferred tax assets and deferred tax liabilities are recognized for the expected future consequences of temporary differences between the financial reporting basis and the tax basis of assets and liabilities. A valuation allowance is provided when it is more likely than not that a deferred tax asset will not be realized.

The Corporation's wholly owned limited liability companies and corporations are treated as partnerships for federal income tax purposes. Consequently, federal income taxes are not payable by, or provided for, by the wholly owned limited liability companies and corporations. The Corporation is taxed individually on the wholly owned limited liability companies and corporation's earnings.

Uncertain Tax Positions: The Corporation applies the income tax standard for uncertain tax positions. As a result of the Corporation evaluates its tax positions and determined it has no uncertain tax positions as of September 30, 2014. The Corporation's 2012 and 2013 tax years are open for examination by federal and state taxing authorities.

Subsequent Events: The Corporation has evaluated subsequent events through June 5, 2015, the date on which the financial statements were available to be issued.

New or Recent Accounting Pronouncements: In May 2014, the FASB issued Revenue from Contracts with Customers (Topic 606). This ASU will affect any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards such as insurance or lease contracts, and will supersede the revenue recognition requirements in Accounting Standards Codification (ASC) Topic 605, *Revenue Recognition*, and most industry-specific authoritative accounting guidance. In addition, this ASU will amend the existing requirements for the recognition of a gain or loss on the transfer of nonfinancial assets that are not in a contract with a customer such as assets within the scope of ASC Topic 360, *Property, Plant, and Equipment*, and intangible assets within the scope of ASC Topic 350, *Intangibles—Goodwill and Other* to be consistent with the guidance on recognition and measurement of this ASU. Under the requirements of this ASU, financial reporting entities should recognize contractual revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The ASU will require a step process for contractual revenue recognition that will require financial reporting entities to identify contractual relationships that produce revenue, identify the performance obligations within those contracts, determine contractual transaction prices of those contracts, allocate the transaction price to the performance obligations of those contracts, and to recognize revenue as the financial reporting entity satisfies the contractual performance obligations. The amendments of this ASU are effective for public entities for annual and interim reporting periods beginning after December 15, 2016, with early application not permitted. For nonpublic entities, the amendments of this ASU are effective for annual reporting periods beginning after December 15, 2017, and interim periods within annual periods beginning after December 15, 2018, with earlier application permitted no earlier than the effective date for public entities. Once adopted, an entity should apply the amendments of the ASU by either retrospectively applying to all

period presented using practical expedients prescribed by the ASU, or retrospectively with the cumulative effect of initial application recognized at the date of initial application with disclosure of the impact that the cumulative effect would have had on individual financial statement line items for the prior periods presented before the initial application. The management of the Corporation has not yet concluded their evaluation of the potential effects of this new accounting and financial reporting standard update.

Note 2. Net Patient Service Revenue

The Corporation has agreements with third-party payors that provide for reimbursement to the Corporation at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Corporation billings at established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with major third-party payors follows:

- **Medicare**

  The HMC Hospitals are licensed as Critical Access Hospitals. Inpatient services and most outpatient services rendered to Medicare program beneficiaries are paid based on a cost reimbursement methodology at 101% of allowable cost. Other outpatient services are paid based on fee schedules.

- **Medicaid**

  Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under various methodologies depending on the particular state in which the Hospital is located. In some circumstances the Hospitals are reimbursed for cost reimbursable services at tentative rates with final settlement determined after submission of annual cost reports by the Hospitals and audits thereof by the Medicaid fiscal intermediary. Other states reimbursement includes prospectively determined rate per discharge, discounts from established charges and prospectively determined daily rates.

- **Other**

  HMC Hospitals have also entered into payment agreements with commercial insurance carriers. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Concentration of Revenues

Revenue from the Medicare and Medicaid programs accounted for approximately 45 percent and 12 percent, respectively, of the Corporation's gross patient revenue, for the year ended September 30, 2014. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation.

The Corporation's patient service revenues are particularly sensitive to regulatory and economic changes in certain states where the Corporation generates significant revenues. The following is an analysis by state of revenues as a percentage of the Corporation's total revenues for those states in which the Corporation generates significant revenues for the year ended September 30, 2014:

	Hospital Campuses in State as of September 30, 2014	Revenue Concentration by State	
		Amount	% of Revenues
Oklahoma	5	$ 29,360,290	33.2%
Tennessee	1	15,112,479	17.1%
North Carolina	2	21,282,779	24.1%
Kansas	3	14,866,124	16.8%
Missouri	1	7,799,530	8.8%
Total		$ 88,421,202	

Charity Care

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Corporation's gross charges. The Corporation evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the local hospital's policy for charity care. The Corporation provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the year ended September 30, 2014, the Corporation estimates that its costs of care provided under its charity care programs approximated $350,000. The Corporation does not report a charity care patient's charges in revenues or in the provisions for doubtful accounts as it is the Corporation's policy not to pursue collection of amounts related to these patients.

The Corporation's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Corporation's gross charity care charges provided. The Corporation's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Corporation's local charity care policies. To the extent the Corporation receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Corporation does not include these patients' charges in its cost of care provided under its charity care program. During the year ended September 30, 2014, the Corporation recognized revenues of approximately $400,000 under such programs.

The Corporation derives a significant portion of its revenues from Medicare, Medicaid and other payors that receive discounts from its established billing rates. The Corporation must estimate the total amount of these discounts to prepare its consolidated financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Corporation estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Corporation's estimates. Additionally, updated regulations and contract negotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Changes in estimates related to the allowance for contractual discounts affect revenues reported in the Corporation's accompanying consolidated statement of operations.

Cost report settlements under reimbursement agreements with Medicare and Medicaid are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. The net adjustments to estimated cost report settlements from prior years resulted in a decrease to net revenue for the year ended September 30, 2014, of approximately $830,000. The Corporation's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Corporation's financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

A summary of gross and net patient service revenue for all of the Corporation's payors for the year ended September 30, 2014:

Gross patient service revenue	$ 202,647,951
Less provision for:	
Contractual adjustments	97,773,794
Provision for bad debts	15,757,181
Charity care	695,774
Net patient service revenue	$ 88,421,202

Patient service revenue, net of contractual adjustments and discounts (but before the provision for bad debts), recognized during the year ended September 30, 2014 from these major payor sources, is as follows:

	Third-Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	$ 91,234,389	$ 12,943,994	$ 104,178,383

Note 3. Cash Concentrations

The Corporation maintains cash and cash equivalents on deposit with financial institutions. At times the balance in these accounts may be in excess of Federally insured limits. However, management believes these financial institutions are financially sound and these concentrations do not present a significant risk to the Corporation.

Note 4. Concentration of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net receivables from patients and third-party payors at September 30, 2014 was as follows:

Medicare	36%
Medicaid	5%
Blue Cross	12%
Commercial and other	29%
Self-pay	18%
	100%

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 5. Assets Limited as to Use

The composition of assets limited as to use at September 30, 2014 is as follows:

Held by trustee under indenture agreements	
Cash and cash equivalents	$ 1,145,088
Total assets limited as to use	$ 1,145,088

Investment income and gains and losses for cash and cash equivalents are comprised of the following for the year ended September 30, 2014:

Income	
Investment income	$ 58,651
	$ 58,651

Note 6. Property and Equipment and Commitments

A summary of property and equipment at September 30, 2014 follows:

Land and land improvements	$ 1,761,165
Buildings and leasehold improvements	28,796,172
Equipment and fixtures	25,209,310
	55,766,647
Less accumulated depreciation and amortization	35,638,152
	20,128,495
Construction in progress	3,207,240
Property and equipment, net	$ 23,335,735

Construction in progress at September 30, 2014 primarily consists of costs incurred for the planning of replacement facilities. The projects are in the planning phase. No commitments for additional cost have been made as of the date of this financial statement report.

Note 7. Long-Term Debt

A summary of long-term debt as of September 30, 2014 is as follows:

Note payable to First Liberty Bank, monthly installments of $59,623, including variable interest of prime plus 1.5% (6.25% at September 30, 2014) through 2037, secured by property and equipment and a second priority on accounts receivable. The note is 90% guaranteed by the U.S. Department of Agriculture.	$ 8,677,531

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note and Mortgage payable to First Liberty Bank, monthly installments of $48,747, including variable interest (4.75% at September 30, 2014) through 2034, secured by accounts receivable and property and equipment. Loan was made to refinance HUD loan and to provide financing for hospital improvements. Loan is 70% guaranteed by the United States Department of Agriculture (USDA).	7,405,946
Note payable to Health Acquisition Company (HAC), LLC , interest only Payable monthly at 7.00% through 2024, loan made for working capital for hospitals, includes pledge of stock and all of the LLC interests. In connection with the loan, HMC granted to HAC the right and option to purchase the Option interests for $6 million to be paid in full by HAC's conversion of the note payable into interests equal to 80% of the total interests of HMC. Term of the option commences on October 1, 2015, and ends on the note maturity date.	6,000,000
Note payable to HPCG Hospital Investments, LLC (HHI), various monthly installments including interest of 6.00% through 2021; secured by accounts receivable and fixed assets (various lien positions).	4,216,000
Note payable to HMC/CAH Note Acquisition, LLC, monthly installments of $64,747, including interest of 7.00% through 2020; secured by accounts receivable and intangibles (various lien positions).	3,706,203
Note payable to Triumph Healthcare (formerly Doral Healthcare), monthly installments of $53,417, including variable interest based on LIBOR (7.00% at September 31, 2014) through 2018; secured by accounts receivable. $1,000,000 of the loan amount is held by the lender as a certificate of deposit and is recorded in Assets Limited as to Use and $500,000 is held by lender in reserve.	2,767,857
Note payable to CFG Community Bank, monthly installments of $18,293, including interest of 6.25% based on 20 year amortization with final balloon payment in January 2016, secured by property and equipment and accounts receivable (various lien positions).	2,304,852
Note payable to shareholders, various monthly installments including interest of 6.00% through September 2018; secured by accounts receivable.	2,133,518
Note payable to Citizens Bank, monthly installments of $10,589, including interest of prime plus 1.5% based on 20 year amortization with one final balloon payment in January 2017, secured by accounts receivable and property and equipment.	1,355,827
Notes payable to Sun Finance, monthly installments of $24,166, including interest of 6.00% through 2018, secured by CAH 4 equity interests; notes were originally for $1.25 million at CAH 6 and CAH 16, reduced to $1M during bankruptcy and debt was transferred to HMC.	1,045,090

Note payable to First Liberty Bank, monthly installments of $7,326, including interest of 6.00% through 2021, secured by accounts receivable and property and equipment.	475,812
Notes payable to various lenders, monthly payments ranging from $1,177 to $15,394, interest at various fixed rates maturing through 2016.	311,930
Capital lease obligations, monthly payments ranging from $538 to $11,829, various rates of interest from 1.625% to 20.028% maturing through 2020, secured by related equipment.	2,737,599
Total long-term debt	43,138,165
Less current maturities	4,747,871
Long-term debt, net of current maturities	$ 38,390,294

Scheduled principal repayments on notes payable and capital lease obligations are as follows:

Year ending September 30,	Notes Payable	Capital Lease Obligations
2015	$ 3,453,827	$ 1,499,605
2016	5,621,061	711,125
2017	4,751,513	568,252
2018	3,632,729	326,034
2019	3,403,526	30,495
Thereafter	19,537,910	15,895
Total	$ 40,400,566	3,151,406
Less: Amount representing interest on obligations under capital lease		413,807
Total		$ 2,737,599

The Corporation had the following assets under capital lease included in property and equipment at September 30, 2014:

Movable equipment	$ 5,561,312
Less: accumulated amortization	3,048,458
Total	$ 2,512,854

Restrictive Covenants

The provisions of the debt agreements described above contain various restrictive covenants related to financial and operational matters to be satisfied as long as the debt is outstanding. As of September 30, 2014, the Corporation did not meet all of these requirements. Subsequent to the year ended September 30, 2014, the Corporation received waivers related to the matters of non-compliance.

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 8. Estimated Third-Party Payor Settlements

Estimated third-party payor settlements consist of amounts due from/(to) the Medicare and Medicaid programs for settlement of current and prior cost reports. A significant amount of the Medicare settlements are on Extended Repayment Plans (ERPs). Terms of the ERP include repayments extending from six months to five years. The estimated settlements by program at September 30, 2014 are as follows:

Medicare	$ (5,721,580)
Medicaid	762,191
Total	(4,959,389)
Less current maturities	(1,227,000)
Long-term portion	$ (3,732,389)

Note 9. Accrued Expenses

Details of accrued expenses at September 30, 2014 are as follows:

Accrued payroll, benefits and payroll taxes	$ 2,013,603
Accrued paid time off	1,795,985
Management fees payable – related party	1,415,437
Accrued property taxes	211,731
Other accrued expenses	2,100,590
	$ 7,537,346

Note 10. Capitalization

The capital stock of the Corporation at September 30, 2014 are as follows:

Common Stock, par value .00001 a share, authorized 4,000,000 shares, issued and outstanding 290,892 shares	$ 290,892
Class 2 Earnout Rights 1,000,000 nonvoting shares – additional paid in capital	1,000,000
Series A Preferred stock, par value .00001 a share, authorized 10,000,000 shares, issued and outstanding 9,571,367 shares	96
Series A Preferred stock, additional paid in capital and accumulated dividends	12,456,765
Series B Preferred Stock – par value .00001 a share, authorized 7,000,000 shares, issued and outstanding 6,363,636 shares	64
Series B Preferred Stock – additional paid in capital	6,999,936
Series C Preferred Stock – par value $.00001 a share, authorized 3,200,000 shares, issued and outstanding 2,909,091 shares	29
Series C Preferred Stock – additional paid in capital	3,199,971
Total capital stock	$ 23,947,753

Class 2 Earnout Rights

Subject to the terms of the Plan, Class 2 Earnout Rights are One Million Dollars ($1,000,000) in non-voting equity interests in the Corporation that are to be provided to Participating New Equity Owners in Ratable Proportion to the funds that such Participating New Equity Owners provide to fund distributions to creditors pursuant to the Joint Plan.

No distributions shall be made to owners of Class 2 Earnout Rights until all senior classes have been paid in full, at which point the Class 2 Earnout Rights will receive distributions on the same terms and conditions and using the same formula as was used for determining distributions in connection with Class 1 Earnout Rights.

Class 2 Earnout Rights will accrue interest at an annual rate of 2%.

Preferred Stock Dividends

The Corporation's Series A Preferred Stock Agreement stipulates that the Series A Preferred Stock will carry an annual 8% cumulative dividend, payable upon a liquidation or redemption. No dividends or distributions can be made with respect to Common Stock until the Series A Preferred Stock has received its liquidation preference. Thereafter, for any other dividends or distributions, preferred participates with Common Stock on an as-converted basis. The Corporation intends to employ all available funds for the development of its business and, accordingly, does not intend to declare or pay any cash dividends on its Series A Preferred Stock or Common Stock in the foreseeable future. As of September 30, 2014, approximately $4,700,000 of dividends have accumulated on the Series A Preferred Stock.

In full satisfaction of its Allowed HHI General Unsecured Claim, HHI received Series B Preferred Stock with comparable economic rights to Series A preferred stock (and with the same priority for any distributions, based on their preferred stock ownership) and Series C Preferred Stock.

Warrants

In accordance with the reorganization plan, the holder of the Sun Finance Secured Claim was granted, upon the Effective Date, (i) 250,000 shares of common stock in Reorganized HMC and (ii) new warrants exercisable for the purchase of 1,250,000 shares of common stock in Reorganized HMC and on the same terms and conditions as those certain warrants issued to the holder of the Sun Finance Secured Claim before the Petition Date and which may be exercised at Sun Finance's discretion.

Note 11. Deferred Revenue

Deferred revenue in the consolidated balance sheet at September 30, 2014, consists of the following:

Management rights sales	$ 2,919,243
Electronic health records incentive payments	1,111,371
	$ 4,030,614

Amounts are classified as follows in the accompanying consolidated balance sheet at September 30, 2014:

Current portion	$ 954,001
Long-term portion	3,076,613
	$ 4,030,614

Note 12. Reorganization Obligations and Earnout Contingency

Reorganization obligations at September 30, 2014 consist of the following:

Cure payable amounts	$ 1,427,522
Earnout payable amounts	1,625,314
	$ 3,052,836

Classification in the consolidated balance sheet at September 30, 2014 is as follows:

Current portion	$ 1,793,640
Long-term portion	1,259,196
	$ 3,052,836

Cure Payable Amounts

Pursuant to the terms of the Plan, certain contracts were assumed by the Corporation as part of the reorganization plan. Cure payments consisting of pre-petition amounts and post-petition amounts owed are being made to those parties over the course of 36 months starting at the date of the confirmation order.

Class 1 Earnout Rights

Pursuant to the terms of the Plan, Class 1 Earnout Rights are those rights of holders of $1,929,257 in Allowed General Unsecured Claims that have elected Option 2 treatment to the payment of 100% of the amount of such Allowed Claims pursuant to interests in a note or notes payable and issued by the Corporation for the aggregate amount of the Class 1 Earnout Rights with each holder's interest equal to the full amount of such holder's Allowed General Unsecured Claim. The Class 1 Earnout Rights shall be paid if certain operating performance benchmarks are met. For the year ended September 30, 2014 those benchmarks were not met.

Class 1 Earnout Rights will accrue interest at an annual rate of 2% which accrued interest shall be payable only at the time of an Option 2 Payment Event.

Note 13. Lessee Lease Commitment and Total Rental Expense

The Corporation leases office and medical space and equipment under long-term operating lease arrangements that expire at various dates. Total rental expense for all operating leases was approximately $1.4 million for 2014.

Note 14. Related Party Transactions

HPCG Hospital Investment, LLC

HPCG Hospital Investment, LLC (HHI) in exchange for its agreement to reduce its secured claim to $5 million, was given a $10 million preferred equity interest in HMC. As of September 30, 2014, HMC has reflected notes payable to HHI totaling $4,216,000, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately $151,000 related to loan agreements with HHI.

Rural Community Hospitals of America, LLC (RCHA)

On January 17, 2013, HMC/CAH, as sellers, and Rural Community Hospitals of America, LLC (RCHA), as buyer, closed the Management Rights Sale transaction. The key financial terms of that transaction were as follows:

1. HMC/CAH received a cash payment of $4,000,000 from RCHA for the purchase of HMC's "home office" assets (i.e. those assets necessary for management of the HMC Hospitals). The amount was recorded as deferred revenue and amortized over the estimated life of the management contracts or approximately 7 years.

2. RCHA hired all of HMC's "home office" employees (i.e. those employees involved in the day-to-day management of HMC/CAH hospitals, including the CEOs of the HMC Hospitals).

3. RCHA assumed certain HMC "home office" liabilities, contracts and leases, including sublicenses and sublets of HMC's Kansas City "home office and central business offices (CBOs) in Tulsa, Oklahoma and Alma, Missouri.

4. HMC/CAH executed management agreements for each of the HMC Hospitals.

5. Pursuant to terms of each management agreement, RCHA (Manager), is to receive a management fee equal to 11% of cash collected. For the year ended September 30, 2014, management fees paid to RCHA were $9,751,500.

RCHA is a West Virginia limited liability company. The President of RCHA directly or indirectly owns a 50% interest in RCHA. The RCHA President owns directly or indirectly a 50% interest in Sun Finance Corporation. The RCHA President was a member of the HMCs' Board of Directors, but resigned from HMCs' Board of Directors prior to HMC engaging RCHA as its management Company. The aggregate of the minimum fees payable to RCHA for all of the subsidiary hospitals is $9,697,000. Total amounts incurred for management fees were approximately $9,750,000 for the year ended September 30, 2014. As of September 30, 2014, HMC has reflected management fees payable to RCHA totaling $1,415,437, included in accrued expenses in the accompanying consolidated balance sheet.

Sun Finance, Inc.

Sun Finance, Inc. (Sun) is the sole member of RCHA. Sun is not a shareholder or holder of an equity interest in HMC. Sun made a loan to HMC in January 2011. The purpose of the loan was for working capital.

Sun Finance was part of the "shareholder loan" in 2011, although they have never been a Series A shareholder. The RCHA President was on the board of directors and the finance committee and is a 50% owner in Sun. Their debt after bankruptcy was transferred to I-70 and part was given to them as Common Stock Warrants. As of September 30, 2014, HMC has reflected notes payable to Sun totaling $1,045,090, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately $25,000, related to loan agreements with Sun.

HMC/CAH Note Acquisition Company, LLC

HMC/CAH Note Acquisition Company, LLC, is related through common ownership of the Corporation's preferred stock. Gemino Healthcare Finance made a loan to HMC and its hospital subsidiaries in fiscal 2010. The purpose of the loan was to provide a revolving credit line and working capital source to HMC and its hospitals. HMC/CAH Note Acquisition Company, LLC, was formed in 2012 for the purpose of purchasing, at par, the revolving credit loan from Gemino Healthcare Finance. The purchase price was paid directly to Gemino Healthcare Finance. Following the closing of the purchase, Note Acquisition received loan payments of principal and interest under the Gemino note directly from HMC and its hospital

subsidiaries. As of September 30, 2014, HMC has reflected notes payable to Note Acquisition totaling $3,706,203, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately $158,000, related to loan agreements with Note Acquisition.

Health Acquisition Company, LLC

Health Acquisition Company, LLC (HAC) participated in a working capital loan to HMC. The members of HAC are Scott L. White, Paul Nusbaum, Steven F. White and Larry A. Pack.

In connection with the loan, HMC granted to HAC the right and option to purchase the Option interest for $6 million to be paid in full by HAC's conversion of the note payable into interests equal to 80% of the total interests of HMC. Term of the option commences on October 1, 2015 and ends on the note maturity date. As of September 30, 2014, HMC has reflected notes payable to HAC totaling $6,000,000, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately $245,000, related to loan agreements with HAC.

Shareholder Notes

This was a loan totaling $2.3 million for use as working capital. All lenders are shareholders, other than Sun Finance. This debt was transferred to I-70 as part of the reorganization plan. As of September 30, 2014, HMC has reflected notes payable to shareholders totaling $2,133,518, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately $56,000, related to loan agreements with shareholders.

Insurance Broker

The Corporation utilizes a Series A Preferred shareholder as an insurance broker for health and workers' compensation insurance. There were no funds paid to them as a result of their brokerage by HMC for the year ended September 30, 2014.

Note 15. Income Taxes

The provision for income tax benefit and change in valuation allowance for the year ended September 30, 2014 consists of the following:

Current	$ -
Deferred	12,491,183
Change in valuation allowance	(12,491,183)
Total benefit for income taxes	$ -

The Corporation's effective income tax rate is lower than what would be expected if the federal statutory rate were applied to income before income taxes primarily because of certain expenses deductible for financial reporting purposes that are not deductible for tax purposes.

Deferred income taxes are provided for certain income and expenses, which are recognized in different periods for tax and financial reporting purposes. Deferred income taxes result primarily from differences in the accounting for depreciation and amortization expenses for financial and tax reporting purposes. The Corporation has net operating loss carry forwards of approximately $15,900,000 to reduce future income tax liabilities which will expire through 2027.

Note 16. Defined Contribution Pension Plan

The Corporation has established a defined contribution pension plan under which employees become participants upon reaching age 21 and completion of one year of service. The Corporation does not match employee contributions. The contributions are deposited with the plan administrator who invests the plan assets in accordance with participant's directives.

Note 17. Commitments and Contingencies

Malpractice Insurance

The Corporation has insurance coverage to provide protection for professional liability losses on a claims made basis. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently will be uninsured.

Litigation

The Corporation is involved in litigation arising in the ordinary course of business. Claims alleging malpractice have been asserted against the Corporation and are currently in various stages of litigation. It is the opinion of management, however, that estimated malpractice costs accrued at September 30, 2014 are adequate to provide for potential losses resulting from pending or threatened litigation as well as claims arising from unknown incidents from services provided to patients that may be asserted.

Asset Retirement Obligation

The *Asset Retirement and Environmental Obligations* Topic 410 of the FASB Accounting Standards Codification, clarifies when an entity is required to recognize a liability for a conditional asset retirement obligation. Management has considered this Topic, specifically as it relates to its legal obligations to perform asset retirement activities, such as asbestos removal, on its existing properties. Management of the Corporation believes that there is an indeterminate settlement date for the asset retirement obligations because the range of time over which the Corporation may settle the obligations is unknown and cannot be estimated. As a result, management cannot reasonably estimate a liability related to these potential asset retirement activities. However, management does not believe that remediation of such obligations will have a material effect on the consolidated financial statements.

Note 18. Fair Value Disclosures

Fair Value Measurements

The *Fair Value Measurements and Disclosures* Topic 820 of the FASB Accounting Standards Codification defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements.

Under the FASB's authoritative guidance on fair value measurements, fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Corporation uses various methods including market, income and cost approaches. Based on these approaches, the Corporation often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Corporation utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques the Corporation is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the

quality and reliability of the information used to determine fair value. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

- Level 1 – Quoted prices for identical assets and liabilities traded in active exchange markets, such as the New York Stock Exchange.
- Level 2 – Observable inputs other than Level 1 including quoted prices for similar assets or liabilities, quoted prices in less active markets, or other observable inputs that can be corroborated by observable market data.
- Level 3 – Unobservable inputs supported by little or no market activity for financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation; also includes observable inputs for nonbinding single dealer quotes not corroborated by observable market data.

Fair Value on a Recurring Basis

The table below presents the recorded amount of assets measured at fair value on a recurring basis.

	Total at September 30, 2014	Fair Value Measurements Using: Level 1	Level 2	Level 3
ASSETS:				
Restricted cash				
Cash and cash equivalents	$ 1,145,088	$ 1,145,088	$ -	$ -
	$ 1,145,088	$ 1,145,088	$ -	$ -

Assets Recorded at Fair Value on a Nonrecurring Basis

The Corporation has no assets and liabilities that are recorded at fair value on a nonrecurring basis.

Note 19. Asset Purchase Agreements Contingencies or Commitments

Prior CAH Acquisitions

Some of the asset purchase agreements for the twelve CAHs included covenants by the Corporation to commence and complete the construction of replacement hospital facilities and medical office buildings within a certain period of time. Some of these agreements also included certain public interest covenants regarding services, indigent care, financial assistance and admission policies, participation in government reimbursement programs and other similar requirements.

If the Corporation failed to substantially comply with the public interest covenants or closed the hospital business without a successor to carry out the terms and conditions of the asset purchase agreement all ownership and facilities associated with the hospital business could revert back to the seller.

Some of these covenants were performed before the Chapter 11 proceedings were filed. The covenants that remained to be performed were not assumed by the Debtors during the Chapter 11 proceeding and (except as noted below with regard to CAH1) the Plan does not include or otherwise obligate the Debtors to perform any of the remaining covenants.

As of September 30, 2014, these liabilities are not reflected in the financial statements, because under section 11 (Discharge of Debtors) of the Confirmation Order, all such liabilities were discharged and the Debtors' liability in respect to all such covenants was extinguished completely effective January 17, 2013.

Chapter 11 Claim of Washington County (NC)

The asset purchase agreement for the acquisition of Washington County Community Hospital included a covenant that within three years from June 1, 2007, the Corporation must either construct a replacement hospital facility or pay Washington County (NC) the liquidated amount of $700,000. The County filed and was granted an unsecured claim based on this covenant. In the Plan, the County elected the Discount Option and was paid $54,348 in full discharge of its unsecured claim on January 17, 2013.

Note 20. Electronic Health Records (EHR)

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments beginning in 2011 for eligible hospitals and professionals that implement and achieve meaningful use of certified electronic health record (EHR) technology that demonstrate improved quality and effectiveness of care. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. An additional Medicaid incentive payment is available to providers that adopt, implement or upgrade certified EHR technology. However, in order to receive additional Medicaid incentive payments in subsequent years, providers must demonstrate continued meaningful use of EHR technology.

During the year ended September 30, 2014, HMC applied for and recognized in other revenue and support $755,301, related to Medicare and Medicaid EHR incentive payments. HMC has recorded deferred revenue of $1,111,372 for the year ended September 30, 2014, for the difference in the amounts of Medicare and Medicaid share of qualifying expenditures and the amounts amortized to income. Management determined the average useful life of the assets is five years; therefore, the expected incentive revenue will be recognized ratably over five years. HMC intends to apply for additional funds in the coming years.

The Corporation's attestation of compliance with the meaningful use criteria is subject to audit by the Federal government or its designee. The recognition of the grant income is based on management's best estimate and the amounts recognized are subject to change. Any subsequent changes in the recognition of the grant income will impact the results of operations in the period in which they occur.

Note 21. Subsequent Events – Sale and Closure of Facilities

Seiling (OK) Community Hospital (Sale):

On July 1, 2009, CAH9 (as buyer) purchased the business and assets of Seiling Community Hospital from Seiling Municipal Hospital Authority (as seller). In connection with the purchase, CAH9 entered into a lease of the hospital facility with the City of Seiling, Oklahoma.

In early 2014, the Authority stated to the Corporation its desires to repurchase the hospital from CAH9. On July 1, 2014, CAH9 (as seller) entered into an agreement to sell the business and assets of the hospital (including the clinic in Vici (OK) and the site for the replacement facility) to the Authority (as buyer). The assets included in the sale were all inventory, fixed and moveable equipment, operating, property and capital leases. The assets excluded from the sale were cash, deposits, escrows, prepaids, certificates of deposit, investments, accounts receivable, cost report receivables for all periods prior to closing. The Authority also assumed all liabilities accruing after the closing. The sales price was $50,000 for the assets and $105,000 for land. The effective date of the sale was October 1, 2014, on which date the lease of the hospital facility from the City terminated.

Yadkin Valley Community Hospital (NC) (Closure):

On May 1, 2010, CAH10 (as buyer) purchased the business and assets of Yadkin Valley Community Hospital Community Hospital from the County of Yadkin, North Carolina (as seller). In connection with the purchase, CAH10 entered into a lease of the hospital facility with the County. The term of the lease expires on July 31, 2015.

On February 16, 2015, the County issued a request for proposal to lease the hospital facility. Three companies responded to the proposal – Hugh Chatham Memorial Hospital (HC), Community Hospital Corporation (CHC) and Wake Forest Baptist Medical Center (WFB). On April 17, 2015, HC withdrew from the sales process. As of the date of this report, no proposals were obtained to assume the operations of this hospital. Management has begun legal and regulatory proceedings to close the Hospital and cease operations. Management does not anticipate the closure of this hospital will have a significant financial impact on the Corporation.

Note 22. Management Plans

In the midst of the challenges facing all rural hospitals overall, improvements continue to be made in HMC operations.

- Savings initiatives have been implemented again in 2014 at each HMC facility. The total savings created represented over 5.65% of annual operating costs; or approximately $5 million. The impact of these savings began to be realized in November 2014.

- HMC divested itself through the sale of Seiling Community Hospital back to the City of Seiling at the end of September, 2014. HMC was providing Seiling with a subsidy of approximately $60,000 per month with little or no opportunity for a hospital replacement. Therefore, the strategic operating decision was made to sell the hospital back to the City.

- The management team has aggressively implemented point of service collections (POS) collections due to the growing amount of deductibles and coinsurance created as part of the Affordable Care Act. This initiative will reduce bad debts and will improve cash flows by over $2.5 million per year over a two year period beginning in 2014.

- The closure of Yadkin Valley is in process as of the report date. The closure of this facility, which has consistently had operating losses, will improve overall financial condition and operating results of the Corporation in future years.

- A number of facilities have expanded outpatient surgery services to respond to decreases in inpatient volumes. This has been accomplished by making improvements to surgical areas, some of which were completed in 2014, as well as by recruiting or making arrangements to share surgeons with other hospitals. These changes are expected to generate $800,000 of additional net revenue in for a service line that has historically been very profitable.

- HMC facilities have added the several new primary care providers as part of an aggressive recruiting campaign. In addition, several new family practice physicians will also begin employment by July/August 2015.

- Efforts are also underway to reduce expenses further at the hospitals by limiting purchased services and other professional fees. Expenses in purchased services in FY 2014 are down $783,651, or 10.02% of operating expenses. Professional Fees are down $669,555 or 21.50%

- In addition, HMC's central billing offices improved processing time efficiency and added technological tools to support such efficiencies.

- Management also adopted a new budget and monitoring process called 6QF that requires corporate operational leadership and the facility CEOs to review quarterly results for ongoing process improvements efforts. Additionally, a new internal audit process was added to verify operating results related to an institution' ongoing cash flow results. The CEOs are now incentivized for their performance which is tied to the results of these new operating processes.

- The leadership team has added several new staff members to the executive team (including a new CFO, COO and Regional VP) to improve overall corporate oversight. All of the new team members have a strong operational background that includes successful tenures as CEOs in critical access hospitals. They have detailed knowledge of hospital operations with daily hands-on experience to work with the hospitals to improve processes while growing revenue to improve profitability.

- Constructing three new facilities utilizing federally secured financing that will result in improved operating results and cash flows at those facilities based upon financial forecast prepared by an independent third party accounting firm. These include: Hillsboro and Oswego in Kansas, and Prague in Oklahoma.

- HMC has started new lines of services in their facilities, these include an OP Psych program at Drumright, genetic lab testing for medication effectiveness at Drumright and Prague, Sleep Lab at Horton and Pain Management Clinic at Hillsboro to name a few.

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED SCHEDULE – BALANCE SHEET INFORMATION
September 30, 2014

	Drumright	Fairfax	Haskell	Hillsboro	Horton	I-70	Lauderdale	Oswego	Prague	Seiling	Washington	Yadkin Valley	HMC	Eliminations	Consolidated
ASSETS															
Current assets															
Cash and cash equivalents	$ 921,389	$ 18,818	$ 42,810	$ 20,695	$ 20,380	$ 22,047	$ 17,606	$ 17,330	$ (6,233)	$ 3,492	$ 13,905	$ 16,333	$ 243,230	$ -	$ 1,349,802
Lockbox transfers	(174,284)	38,549	188,175	50,619	16,569	-	1,133	(508,738)	10,892	102,680	-	272,305	-	-	-
Patient accounts receivable, net	1,445,366	733,501	1,038,036	903,189	712,032	1,119,783	2,102,935	780,024	816,939	273,020	1,627,814	1,560,498	-	-	12,913,137
Inventory of supplies	199,260	236,751	251,883	216,871	165,071	119,892	209,237	78,356	110,378	42,992	256,901	183,255	-	-	2,070,845
Prepaid expenses	271,156	188,707	212,578	70,452	93,421	289,292	439,424	65,823	183,420	93,990	260,044	258,788	(3,949)	-	2,424,146
Due from (to) related party	3,314,703	159,828	2,148,290	1,234,549	1,967,786	(399,426)	2,765,377	3,135,200	625,660	(562,574)	(1,093,624)	1,233,805	(14,529,404)	-	-
Other receivables	-	335	-	-	52,988	-	-	2,824	-	-	-	-	-	-	56,117
Total current assets	5,977,590	1,375,559	3,881,772	2,495,375	3,028,247	1,151,588	5,535,712	3,572,819	1,541,054	(46,400)	1,065,040	3,525,014	(14,290,123)	-	16,814,047
Property and equipment, net	5,909,465	639,557	646,623	792,008	463,403	6,458,597	2,093,766	3,108,113	867,065	-	1,717,749	534,799	32,492	-	23,335,735
Assets limited as to use	145,000	-	-	-	-	-	-	-	-	-	-	-	1,000,088	-	1,145,088
Other assets															
Investment in subsidiaries	-	-	-	-	-	-	-	-	-	-	-	-	9,447,301	(9,447,301)	-
Deferred financing cost, net	444,354	-	-	-	-	183,164	35,133	-	-	-	-	-	123,823	-	786,474
	444,354	-	-	-	-	183,164	35,133	-	-	-	-	-	9,571,124	(9,447,301)	786,474
Total assets	$ 12,476,409	$ 2,015,226	$ 4,528,395	$ 3,288,383	$ 3,491,650	$ 7,793,349	$ 7,664,611	$ 6,770,932	$ 2,408,919	$ (46,400)	$ 2,782,788	$ 4,059,804	$ (3,686,419)	$ (9,447,301)	$ 44,081,344
LIABILITIES AND STOCKHOLDERS' EQUITY (DEFICIT)															
Current liabilities															
Current installments of long-term debt	$ 382,858	$ 158,854	$ 80,277	$ 108,255	$ 164,132	$ 670,566	$ 560,085	$ 121,190	$ 44,846	$ 15,164	$ 441,533	$ 125,577	$ 1,674,534	$ -	$ 4,747,871
Deferred revenue-current portion	36,348	71,636	69,872	-	-	54,665	72,994	-	57,160	-	-	-	571,428	-	954,001
Accounts payable	896,841	676,665	1,138,057	418,097	911,208	1,469,085	1,649,522	514,708	767,958	465,494	1,319,686	838,392	501,711	-	11,567,034
Reorganization obligations-current portion	131,831	126,783	123,207	114,546	131,175	74,006	126,528	113,973	109,576	126,115	151,684	282,782	181,424	-	1,793,640
Estimated third-party settlements	970,906	331,722	753,886	93,778	(158,920)	(615,194)	(823,151)	560,865	(395,859)	177,996	(706,987)	1,039,866	-	-	1,227,000
Accrued expenses	576,715	476,513	454,687	443,056	575,852	803,575	1,346,663	326,408	483,276	299,626	981,150	709,966	48,629	-	7,537,346
Total current liabilities	2,994,497	1,842,083	2,629,996	1,179,732	1,623,447	2,556,703	2,932,671	1,637,234	1,076,557	1,084,397	2,185,066	2,996,583	2,977,926	-	27,626,892
Long-term debt, excluding current portion	7,600,221	110,790	78,401	269,506	609,224	10,540,553	3,467,744	482,128	61,962	-	3,084,784	234,065	11,849,916	-	38,390,294
Reorganization obligations, excluding current portion	150,526	25,679	46,642	12,979	43,723	3,748	62,724	12,017	6,226	3,079	103,759	758,670	19,429	-	1,259,195
Estimated third-party payor settlements	670,671	370,291	524,963	362,172	174,046	116,459	583,132	646,734	-	126,979	7,085	149,867	-	-	3,732,389
Deferred revenue	36,348	143,072	139,745	-	-	129,329	145,988	-	134,320	-	-	-	2,347,815	-	3,076,613
Total liabilities	11,452,263	2,491,901	3,420,747	1,824,389	2,450,440	13,456,790	7,192,257	2,778,113	1,279,065	1,214,454	5,380,694	4,149,185	17,195,086	-	74,285,384
Stockholders' equity (deficit)															
Members equity	2,871,458	1,365,263	1,540,835	1,308,902	879,290	1,000,000	667,380	204,636	1,555,299	145,000	1,254,056	-	-	(12,692,819)	-
Preferred stock	-	-	-	-	-	-	-	-	-	-	-	-	22,656,861	-	22,656,861
Common stock	-	-	-	-	-	-	-	-	-	-	-	-	1,290,892	-	1,290,892
Retained earnings	(1,847,312)	(1,850,938)	(433,187)	155,392	161,920	(6,663,441)	(195,026)	3,788,183	(425,445)	(1,406,854)	(3,851,964)	(89,381)	(44,829,258)	3,245,519	(54,151,793)
Total stockholders' equity (deficit)	1,024,146	(485,675)	1,107,648	1,463,994	1,041,210	(5,663,441)	462,354	3,992,819	1,129,854	(1,260,854)	(2,597,908)	(89,381)	(20,881,505)	(9,447,301)	(30,204,040)
Total liabilities and stockholders equity (deficit)	$ 12,476,409	$ 2,006,226	$ 4,528,395	$ 3,288,383	$ 3,491,650	$ 7,793,349	$ 7,654,611	$ 6,770,932	$ 2,408,919	$ (46,400)	$ 2,782,788	$ 4,059,804	$ (3,686,419)	$ (9,447,301)	$ 44,081,344

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED SCHEDULE – OPERATING INFORMATION
Year Ended September 30, 2014

	Drumright	Fairfax	Haskell	Hillsboro	Huron	I-70	Lauderdale	Osawgo	Prague	Selling	Washington	Yadkinvalley	Consolidated Hospitals	HMC	Eliminations	Consolidated
Revenues																
Gross patient revenue	$ 21,458,773	$ 10,034,190	$ 10,039,281	$ 6,840,570	$ 12,595,282	$ 13,802,345	$ 39,355,904	$ 7,358,785	$ 11,455,682	$ 4,816,748	$ 33,090,916	$ 22,868,508	$ 202,647,951	$ -	$ -	$ 202,647,951
Contractual allowance	(11,958,543)	(4,349,054)	(10,741,260)	(2,236,360)	(5,375,299)	(4,703,763)	(29,231,496)	(2,768,570)	(5,699,757)	(1,243,770)	(16,344,298)	(10,720,483)	(97,773,794)	-	-	(97,773,794)
Charity care	(16,966)	(28,178)	(12,765)	(89,617)	(63,535)	(61,641)	(178,674)	(30,607)	(53,610)	(31,178)	(92,891)	(18,657)	(609,774)	-	-	(609,774)
Provision for bad debts	(1,023,062)	(690,201)	(1,111,059)	(143,654)	(678,076)	(1,037,211)	(3,835,255)	(120,560)	(720,075)	(374,723)	(2,590,672)	(3,023,333)	(15,757,181)	-	-	(15,757,181)
Net patient service revenue	8,600,676	4,766,727	7,174,197	4,165,748	6,256,348	7,799,530	15,112,479	4,441,028	5,556,640	3,167,077	12,057,254	8,226,525	88,421,202	-	-	88,421,202
Other operating revenue	74,167	24,764	28,606	52,721	188,894	73,771	318,742	47,836	39,378	47,367	64,647	95,235	1,041,918	571,802	(163,376)	1,450,344
Electronic health record incentive reimbursement	36,347	211,535	79,873	-	-	64,779	295,608	-	67,158	-	-	-	755,301	-	-	755,301
Total revenues	8,761,193	5,003,026	7,282,736	4,219,469	6,445,242	7,938,080	15,727,829	4,488,866	5,662,176	3,214,444	12,121,901	8,320,760	90,218,421	571,802	(163,376)	90,626,847
Expenses																
Salaries and wages	4,243,508	2,764,843	3,331,083	2,252,179	3,501,209	3,584,061	8,292,318	2,456,769	3,118,193	1,687,503	5,282,931	4,403,711	43,098,108	-	(163,376)	42,934,730
Payroll taxes and benefits	583,766	552,768	511,608	396,673	558,924	608,430	1,424,874	361,415	499,866	285,794	1,079,117	958,390	7,850,655	-	-	7,850,655
Supplies and other	1,526,703	968,399	1,578,364	845,284	1,269,833	1,509,146	2,502,565	806,093	1,058,475	578,355	2,117,460	1,400,844	16,163,844	175,430	-	16,339,274
Medical professionals	300	-	467,173	213,824	81,023	124,295	856,464	93,340	5,990	92,220	954,184	516,803	3,226,316	-	-	3,226,316
Purchased services	640,716	455,191	534,608	363,550	749,080	567,941	871,527	260,644	656,993	488,270	787,072	933,508	7,883,081	531,041	-	8,194,122
Management fees	1,035,000	515,998	516,996	585,996	770,004	822,327	1,419,996	513,000	663,191	519,996	1,275,000	891,996	9,751,498	-	-	9,751,498
Depreciation and amortization	746,284	200,992	170,933	97,466	242,982	817,109	988,070	140,012	134,588	39,630	497,287	252,155	4,237,758	-	-	4,237,758
Interest expense	556,862	89,125	56,773	155,663	93,532	675,683	369,272	122,557	19,170	81,383	364,043	101,956	2,675,059	607,319	-	3,282,378
Total expenses	9,632,137	5,548,714	7,293,538	4,932,335	7,233,567	8,710,992	14,545,486	4,755,830	6,170,469	3,973,151	12,247,094	9,491,364	94,666,317	1,313,790	(163,376)	95,816,731
Operating income (loss)	(870,944)	(545,688)	(10,802)	(712,866)	(788,125)	(800,912)	1,182,343	(267,164)	(494,294)	(758,707)	(125,253)	(140,444)	(4,447,896)	(741,988)	-	(5,189,884)
Non-operating income																
Investment income	2,197	175	500	6,525	44,668	1,076	518	63	429	120	833	259	56,563	88	-	56,651
Net income (loss)	$ (868,747)	$ (545,513)	$ (10,302)	$ (705,941)	$ (743,457)	$ (799,836)	$ 1,182,861	$ (267,101)	$ (493,865)	$ (758,587)	$ (124,420)	$ (140,185)	$ (4,393,333)	$ (741,900)	$ -	$ (5,131,233)

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 14

Section C, Orderly Development of Healthcare, Item 7 (c)

Facility License

Board for Licensing Health Care Facilities

State of Tennessee

0000000088

No. of Beds 0025

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

CAH ACQUISITION COMPANY 11, LLC *to conduct and maintain a*

Hospital LAUDERDALE COMMUNITY HOSPITAL

Located at 326 ASBURY AVENUE, RIPLEY

County of LAUDERDALE *, Tennessee.*

This license shall expire MARCH 31 *,* 2016 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 31ST *day of* MARCH *,* 2015 *.*

In the Distinct Category(ies) of: PEDIATRIC BASIC HOSPITAL
CRITICAL ACCESS HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By [signature]
COMMISSIONER

DCF011

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 15

Section C, Orderly Development of Healthcare, Item 7 (d)

Most Recent Certification of Licensure with any deficiencies and subsequent Action Plans

DNV·GL

October 26, 2015

Tammie Hardy
Chief Executive Officer
CAH Acquisition Company 11, LLC
d/b/a Lauderdale Community Hospital
326 Asbury Ave
Ripley, TN 38063

Program: CAH
CCN: 441314
Survey Type: Medicare Recertification/DNV Reaccreditation
Certificate #: 188730-2015-AHC-USA-NIAHO
Survey Dates: July 28-29, 2015
Accreditation Decision: Full accreditation
Date Acceptable Plan of Correction Received: 9/24/2015
Method of Follow-up: Acceptable Plan of Correction, Self- Attestation, Document Review
Effective Date of Accreditation: 8/1/2015
Expiration Date of Accreditation: 8/1/2018
Term of Accreditation: Three (3) years

Dear Ms. Hardy:

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, CAH Acquisition Company 11, LLC d/b/a Lauderdale Community Hospital is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485) and awarded full accreditation for a three (3) year term effective on the date referenced above. DNV GL Healthcare USA, Inc. is recommending your organization for continued deemed status in the Medicare Program.

This accreditation is applicable to all facilities operating under the above-referenced CCN number at the following address(es):

CAH Acquisition Company 11, LLC d/b/a Lauderdale Community Hospital - 326 Asbury Ave - Ripley, TN 38063

This accreditation also encompasses the swing beds in place and CAH Acquisition Company 11, LLC d/b/a Lauderdale Community Hospital is deemed in compliance with the Medicare Conditions of Participation at 42 C.F.R §485.645 to meet the special requirements for CAH providers of long-term care services ("swing-beds").

This accreditation requires an annual survey and the organization's continual compliance with the DNVHC Accreditation Process. Failure to complete these actions or otherwise comply with your Management System Certification/Accreditation Agreement may result in a change in your organization's accreditation status.

Congratulations on this significant achievement.

Sincerely,

Patrick Horine
Chief Executive Officer
cc: CMS CO and CMS RO IV (Atlanta)

DNV GL- Healthcare
400 Techne Center Drive, Suite 100
Milford, OH 45150
866-523-6842
dnvclientdropbox@dnvgl.com
www.dnvglhealthcare.com

Survey Report and Corrective Action Plan Submittal Form

DNV·GL

Organization: Lauderdale Community Hospital – Ripley, TN

Survey Date: July 28 - 29, 2015

Survey type: NIAHO (CAH)(Reaccreditation) ISO Stage 2 (Compliance)

Report Date: August 12, 2015

DNV GL Project #: PRJC-389121-2012-MSL-USA

CAP received date: August 21, 2015

Clarification request date: September 18, 2015 (due to DNV GL HC by September 25, 2015)

Updated CAP received date: September 22, 2015; Updated September 24, 2015

Objective Evidence for NC-1 non-conformance category finding(s) due: January 21, 2016 (within 60 **business** days from date the client is notified via email of approval by DNV GL HC)

The Organization must complete the Corrective Action Plan in the section below marked "Organization Response" DNV GL- Healthcare Surveyors will follow-up on all corrective action plans during the next survey or as required if prior to next survey

Total Number of Nonconformities: 0 NC-1 Condition-level 8 NC-1 5 NC-2

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-1	**Quality Management System** ISO 9001 Quality Management System (Control of Documents)	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**QM.2 (SR.3) / (SR.3a)** *ISO 9001:2008;4.2.3*	485.641(b)

Requirement (Description):

SR.3 The organization will initiate and continue implementation of the ISO 9001 methodology to achieve compliance or certification as stated in QM.1. The organization will initiate a process to begin the implementation to address:

SR.3a Control of Documents: the organization's documents (i.e. policies, procedures, forms) are structured in a manner to ensure that only the proper revisions are available for use;

ISO 9001:2008;4.2.3 Control of documents

Documents required by the quality management system shall be controlled. Records are a special type of document and shall be controlled according to the requirements given in 4.2.4.
A documented procedure shall be established to define the controls needed
a) to approve documents for adequacy prior to issue,
b) to review and update as necessary and re-approve documents,
c) to ensure that changes and the current revision status of documents are identified,
d) to ensure that relevant versions of applicable documents are available at points of use,
e) to ensure that documents remain legible and readily identifiable,
f) to ensure that documents of external origin determined by the organization to be necessary for the planning and operation of the quality management system are identified and their distribution controlled, and
g) to prevent the unintended use

The requirement was NOT MET as evidenced by the following:

Please note this nonconformity remains open from the previous survey and has been elevated to an NC-1.

Finding #1
A review of the organization's current document control procedure/process revealed that the controls related to external documents have not been fully addressed and/or established. This deficiency is a "carry-over" from the previous survey.

Finding #2:
During the survey process, some policies were found to be out of compliance with the organization's current document control procedure/process:

1. Emergency Department *Plan of Care* form: Does not include revision date or form number to reference if need to edit form.
2. Medical-Surgical unit: Crash cart had two different versions of the Broselow pediatric tape (version 2007 Edition B and version 2011 Edition A).
3. Hospital is using old version of the CMS "Important Message from Medicare" notice (Form #5201.5; Rev. 3/2010). Hospital staff was not aware of new version available (Form: CMS-R-193; Approved 7/2010) which includes a section to document the time when the patient signs and dates form.
4. The Blueprint for Quality and Patient Safety 2015 did not follow the same format as other policies.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Did not have a full understanding of what the external documents were; therefore, could not address or establish controls.
#2 a. Policies were found out of compliance /without consistency. New form was not created with form number and was not updated with revision number as required.
#2 b. The 2007 Broselow pediatric tape was on the pediatric crash cart in addition to the newest version of 2011. Use of old materials in training was cause of accidental placement of old materials back into cart.
#2 c. "Important Message from Medicare" notice was old version, 3/2010. Hospital staff was not aware of new version available due to being under new management and not having support from the large company anymore. LCH staff was responsible to obtain own information and all reference links had not been set up at that time.
#2 d. The Blueprint for Quality and Patient Safety 2015 was formatted incorrectly for the manual by the prior Quality personnel.

Organization Corrective Action Plan (CAP): #1 New Quality personnel has researched external documents and now better understands definition. Policy on Control of Records and Documents describes our external documents, replacement and/or retention of those documents. This will be communicated at upcoming employee meetings/forums.
#2 a. Policies were found out of compliance /without consistency. ED POC form will include a form number and a revision date going forward to comply with policy and regulations.
#2 b. The 2007 Broselow pediatric tape was disposed of at the time of the survey. Policy will be followed going forward to dispose of old documents when replacing with new documents, according to retention policy and control of records.
#2 c. "Important Message from Medicare" notice has been replaced with the most recent approved version, 7/2010, to document time. Registration and admission clerks/personnel are being trained/educated on completion of the newest form.
#2 d. The Blueprint for Quality and Patient Safety 2015 has now been put into policy format and includes newest available information for quality management program.

Person/Function responsible for implementation of Corrective Action Plan:	Michelle Simpson, Heather Fowlkes, Cheryl Manns Quality Educator HIM Director
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly Multidisciplinary Policy Review Council (MPRC) to review all forms prior to going to MSQI to ensure form #/revision#; Monthly review of websites by quality to ensure all new data is available as soon as possible. Develop indicator on Quality data to check off this monthly action. Old documents to be disposed of as new documents arrive to replace as per record retention guidelines/policy/matrix.

DNV GL- HEALTHCARE USE ONLY

***CAP accepted date:* 9/15/15**	***DNV GL reviewer:* jlds**
Clarification requested date:	***DNV GL reviewer:***

DNV GL- Healthcare
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Survey Report and Corrective Action Plan Submittal Form

DNV·GL

Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.***
- ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.***

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

Provide performance measure(s) data, findings, results of internal reviews (internal audits), or other supporting documentation, including timelines to verify implementation of the corrective action measure(s). Documentation should also include, ***as applicable****:*

- *Policy name and number / version, approval date & approved by*
- *Date education completed, % of education completed, plans for staff who did not complete education, including current staff, new hires and plans for ongoing competency*
- *Internal Audit (IA): objective evidence should reference the audit schedule including the cycle or time period for which it covers (i.e. 2015, 2015-2016, etc.), audit titles or key processes covered, date(s) audits were conducted, date(s) IA findings were addressed/followed up, CAP validation date, etc.*
- *Management Review: meeting dates, summarized information that addresses the inputs and outputs as required*

Providing dates, internal file titles and numbers (i.e. policy number, form number, etc.), and titles of those involved in the implementation are key. The objective evidence submitted should allow for an auditor to trace the corrective action with enough specificity at the next onsite survey activity and provide performance measure(s) data, findings, and results of IA to attest to implementation of the corrective action.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:
Submission date:
Objective evidence summary:

[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].

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Survey Report and Corrective Action Plan Submittal Form

DNV·GL

Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-2	**Quality Management System** ISO 9001 Quality Management System (Control of Records)	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**QM.2 (SR.3) / (SR.3b)** *ISO 9001:2008;4.2.4*	485.641(b)

Requirement (Description):

SR.3 The organization will initiate and continue implementation of the ISO 9001 methodology to achieve compliance or certification as stated in QM.1. The organization will initiate a process to begin the implementation to address:

SR.3b Control of Records: the organization ensures that suitable records are maintained for the CoP and NIAHO® requirements;

ISO 9001:2008;4.2.4 Control of records

Records established to provide evidence of conformity to requirements and of the effective operation of the quality management system shall be controlled.
The organization shall establish a documented procedure to define the controls needed for the identification, storage, protection, retrieval, retention and disposition of records.
Records shall remain legible, readily identifiable and retrievable.

The requirement was NOT MET as evidenced by the following:

Please note that this nonconformity remains open from the previous survey and has been elevated to an NC-1.

The organization has a record control procedure and matrix; however, it does not adequately address the controls needed for identification, storage, protection, and retrieval of records. In addition, the matrix does not encompass all of the "ISO" specific records that must be controlled. For example, the records related to internal audits and corrective actions are not addressed in the organization's record control matrix.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: We have a record retention matrix that does not address internal audits and corrective actions. Internal audits were just implemented this year.

Organization Corrective Action Plan (CAP): We will correct our record retention matrix and add verbiage to the control of records and documents policy.

Person/Function responsible for implementation of Corrective Action Plan:	Cheryl Manns, HIM, Risk manager Michelle Simpson CNO/Quality
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	The Control of Records and Documents policy and record retention matrix will go before MPRC (Multidisciplinary Policy Review Council) annually for update and revisions.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date:	***DNV GL reviewer:***
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***
DNV GL final follow-up and closure of NC:	

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Survey Report and Corrective Action Plan Submittal Form

DNV·GL

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.***
- ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.***

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].

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Survey Report and Corrective Action Plan Submittal Form

DNV·GL

Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-3	**Quality Management System** System Requirements	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**QM.6 (SR.2) / (SR.3)** *ISO 9001:2008;4.2.1* *ISO 9001:2008;4.2.2*	

Requirement (Description):

In establishing the Quality Management System, the CAH shall be required to have the following as a part of this system:

SR.2 Written document defining the scope of the Quality Management System, to include all clinical and non-clinical services;

SR.3 Statement of the Quality Policy;

ISO 9001:2008;4.2.1 General

The quality management system documentation shall include
a) documented statements of a quality policy and quality objectives,
b) a quality manual,
c) documented procedures and records required by this International Standard, and
d) documents, including records, determined by the organization to be necessary to ensure the effective planning, operation and control of its processes.

ISO 9001:2008;4.2.2 Quality manual

The organization shall establish and maintain a quality manual that includes
a) the scope of the quality management system, including details of and justification for any exclusions (see 1.2),
b) the documented procedures established for the quality management system, or reference to them, and
c) a description of the interaction between the processes of the quality management system.

The requirement was NOT MET as evidenced by the following:

Please note that this nonconformity remains open from the previous survey and has been elevated to an NC-1.

The organization's current quality manual, "The Blueprint for Quality and Patient Safety 2015", does not adequately address or include all of the above listed required elements of a compliant quality manual. Specifically, the document does not address ISO exclusions i.e. 7.3 Design and Development.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: Limited understanding of quality management system by the new Quality staff.

Organization Corrective Action Plan (CAP): "The Blueprint for Quality and Patient Safety 2015" has been updated to include correct policy formatting, a commitment to comply with all regulations, and exclusions as well as documented procedures for non-conforming products, control of records and nursing policies.

Person/Function responsible for implementation of Corrective Action Plan:	Michelle Simpson, Quality
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	The Quality Policy management will go through MPRC (Multidisciplinary Policy Review Council) annually with discussion of measures of effectiveness at Quality meeting annually.

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DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: 9/15/15	***DNV GL reviewer:* jlds**
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.***
- ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.***

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].

Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-4	**Anesthesia Services** Policies and Procedures	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**AS.3 (SR.1) / (SR.2) / (SR.2a) / (SR.2c) / (SR.2c(1)** *ISO 9001:2008;7.5.1* *ISO 9001:2008;8.2.3*	485.639(b) 485.639(b)(1) 485.639(b)(2)

Requirement (Description):

AS.3 POLICIES AND PROCEDURES

SR.1 Policies on anesthesia/sedation procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities.

SR.2 The policies must ensure that the following are provided for each patient:

SR.2a a pre-anesthesia or pre-sedation evaluation must be performed for each patient who will receive general, regional or monitored anesthesia. Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner, however a pre anesthesia evaluation is not required because moderate sedation is not considered to be "anesthesia" and is not subject to this requirement. This evaluation will include a documented airway assessment, anesthesia risk assessment, and anesthesia drug and allergy history, by an individual qualified and privileged to administer anesthesia/sedation, immediately before or procedure requiring anesthesia services

SR.2c for inpatient or outpatient surgery, a post-anesthesia evaluation for proper anesthesia recovery is completed and documented within 48 hours after surgery or prior to discharge if less than 48 hours by the individual who administers the anesthesia or, if approved by the medical staff, by any individual qualified and credentialed to administer anesthesia or as identified in AS.2 SR.3;

SR.2c(1) A post-anesthesia evaluation for anesthesia recovery is required each patient who will receive general, regional or monitored anesthesia. Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner, however, a post-anesthesia evaluation is not required because moderate sedation is not considered to be "anesthesia" and is not subject to this requirement. This evaluation must be completed in accordance with State law and CAH policies and procedures approved by the medical staff and reflect current standards of care.

Interpretive Guidelines:

Pre-anesthesia evaluation:

In accordance with current standards of anesthesia care, the pre-anesthesia evaluation of the patient includes, at a minimum:
☐ *Review of the medical history, including anesthesia, drug and allergy history;*

☐ *Interview and examination of the patient;*

☐ *Notation of anesthesia risk according to established standards of practice (e.g. ASA classification of risk);*

☐ *Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);*

☐ *Additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);*

☐ *Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.*
Post-anesthesia evaluation:
A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The evaluation is required any time general, regional, or monitored anesthesia has been administered to the patient. While current practice dictates that the patient receiving moderate (conscious) sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, a post-anesthesia evaluation is not required.

The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area. Except in cases where post-operative sedation is necessary for the optimum medical care of the patient (e.g., ICU), the evaluation generally would not be performed immediately at the point of movement from the operative area to the designated recovery area. Accepted standards of anesthesia care indicate that the evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc. The evaluation can occur in the PACU/ICU or other designated recovery location. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge. The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:
☐ *Respiratory function, including respiratory rate, airway patency, and oxygen saturation;*

☐ *Cardiovascular function, including pulse rate and blood pressure;*

☐ *Mental status;*

☐ *Temperature;*

☐ *Pain;*

☐ *Nausea and vomiting; and*

☐ *Postoperative hydration.*

☐ *Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.*

ISO 9001:2008;7.5.1 Control of production and service provision

The organization shall plan and carry out production and service provision under controlled conditions.
Controlled conditions shall include, as applicable,
a) the availability of information that describes the characteristics of the product,
b) the availability of work instructions, as necessary,
c) the use of suitable equipment,
d) the availability and use of monitoring and measuring equipment,
e) the implementation of monitoring and measurement, and
f) the implementation of product release, delivery and post-delivery activities.

ISO 9001:2008;8.2.3 Monitoring and measurement of processes

The organization shall apply suitable methods for monitoring and, where applicable, measurement of the quality management system processes. These methods shall demonstrate the ability of the processes to achieve planned results. When planned results are not achieved, correction and corrective action shall be taken, as appropriate.

NOTE: When determining suitable methods, it is advisable that the organization consider the type and extent of monitoring or measurement appropriate to each of its processes in relation to their impact on the conformity to product requirements and on the effectiveness of the quality management system.

The requirement was NOT MET as evidenced by the following: In four (4) of four (4) medical records reviewed related to the pre- and post-anesthesia evaluation, the following was identified: **Finding #1: Pre-Anesthesia Evaluation** (1 of 4 records reviewed) MR#13: The pre-anesthesia evaluation lacked documentation of the anesthesia history. **Finding #2: Post-Anesthesia Evaluation** (4 of 4 records reviewed) MR#10, #11, #12 & #13: The post-anesthesia evaluation lacked documentation of the hydration status.
Corrective Action Plan due date: August 22, 2015
ORGANIZATION RESPONSE
Cause that led to the nonconformity: #1 Anesthesia history has all points available to cover on form; however, the CRNA missed a couple of items that could have been pertinent to the history. #2 Hydration status was not listed on the anesthesia record and therefore, inadvertently missed as an assessment.
Organization Corrective Action Plan (CAP): Anesthesia staff will be trained by surgery supervisor to address all pertinent findings in history. #2 Hydration status has been added the to form# 5119.1, revised 7/15;

Person/Function responsible for implementation of Corrective Action Plan:	Denise Nichols, Surgery supervisor
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Anesthesia history and hydration status will be monitored for completion by surgery staff on a monthly basis on Quality to ensure sustained compliance with 100% history/hydration status.
DNV GL- HEALTHCARE USE ONLY	
***CAP accepted date:* 9/15/15**	***DNV GL reviewer:* jlds**
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.***
- ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.***

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such

document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.
Submitted by:
Submission date:
Objective evidence summary: *[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].*

Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-5	**Patient Rights** Specific Rights	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**PR.1 (SR.1)** *ISO 9001:2008;7.2.1*	

Requirement (Description):

PR.1 SPECIFIC RIGHTS

The CAH shall inform, whenever possible, each patient and/or legal representative of the patient's rights in advance of providing or discontinuing care. The written listing of these rights shall be provided to the patient and /or family and shall include policies and procedures that address the following:

SR.1 Beneficiary Notice of non-coverage and right to appeal premature discharge;

ISO 9001:2008;7.2.1 Determination of requirements related to the product

The organization shall determine
a) requirements specified by the customer, including the requirements for delivery and post-delivery activities,
b) requirements not stated by the customer but necessary for specified or intended use, where known,
c) statutory and regulatory requirements applicable to the product, and
d) any additional requirements considered necessary by the organization.

NOTE: Post-delivery activities include, for example, actions under warranty provisions, contractual obligations such as maintenance services, and supplementary services such as recycling or final disposal.

200.3 - Notifying Beneficiaries of their Right to an Expedited Review
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)
Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily-required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

200.3.2 - The Follow-Up Copy of the Signed Important Message from Medicare
(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)
A "follow-up" copy of the signed IM must be delivered to the beneficiary using the following guidelines:

***Delivery Timeframe**. The follow-up copy must be delivered as far in advance of discharge as possible, but no more than 2 calendar days before the planned date of discharge. Thus, when discharge seems likely within 1- 2 calendar days, hospitals should make arrangements to deliver the follow-up copy of the notice, so that the beneficiary has a meaningful opportunity to act on it. However, when discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge, if necessary. If the follow-up copy of the notice must be delivered on the day of discharge, hospitals must give beneficiaries who need it at least 4 hours to consider their right to request a QIO review. Beneficiaries may choose to leave prior to that time; however, hospitals must not pressure a beneficiary to leave during that time period. If the hospital delivers the follow-up copy, and the beneficiary status subsequently changes, so that the discharge is beyond the 2-day timeframe, hospitals must deliver another copy of the signed notice again within 2 calendar days of the new planned discharge date. Hospitals may not develop procedures for delivery of the follow up copy routinely on the day of discharge.*

***Beneficiary Signature and Date**. The IM must be signed and dated by the beneficiary to indicate that he or she has received the notice and can comprehend its contents, unless an appropriate reason for the lack of signature is recorded on the IM, such as a properly annotated signature refusal.*

Alternative to Delivery of the Signed Copy. *A hospital may choose to deliver a new copy of the IM (not a copy of the signed IM) during the required timeframes; however, the hospital must obtain the beneficiary's or representative's signature and date on the notice again at that time.*

Exception to Delivery of the Follow-Up Copy. *If delivery of the original IM is within 2 calendar days of the date of discharge, no follow-up notice is required. For example, if a beneficiary is admitted on Monday, the IM is delivered on Wednesday and the beneficiary is discharged on Friday, no follow-up notice is required.*

If a beneficiary receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered if delivery of the initial copy occurred more than 2 calendar days prior.

Documentation. *Hospitals must document timely delivery of the follow-up copy of the IM in the patient records, when applicable. Hospitals are responsible for demonstrating compliance with this requirement. If hospitals have processes in place to document delivery of other information related to discharge that includes a beneficiary signature and date, hospitals may include the follow-up copy of the notice in those documents. If there are no other existing processes in place, hospitals may use the "Additional Information" section of the IM to document delivery of the follow-up copy, for example, by adding a line for the beneficiary's or representative's initials and date.*

Reference: Medicare Claims Processing Manual, Chapter 30 - Financial Liability Protections (Rev. 2878, 02-21-14).

The requirement was NOT MET as evidenced by the following:

Finding #1: Medical Records
In seven (7) of seven (7) medical records reviewed related documentation of the beneficiary notice of non-coverage and right to appeal premature discharge ("*Important Message from Medicare*"), the following were identified:

a. MR#6 & #7: Open records, patients > 65 years of age, inpatient status: Unable to locate *initial* beneficiary notice in the medical record.
b. MR#4, #6, #7, #9, #15 & #17: Closed record, patient 82 years old, inpatient status: Unable to locate discharge notice in the medical record.
c. MR #9: Admitted to observation status on 7/22/2015, then to inpatient status on 7/24/2015. Initial beneficiary notice was signed and dated for *7/29/2015* (record was reviewed on *7/28/2015*). Either date was > within 2 days of admission.
d. MR #18: Notice presented was dated on day of discharge. However, not signed (or timed) by patient.

Finding #2: CMS Beneficiary Notice Form
It was identified that the hospital has been utilizing an outdated beneficiary notice for patients to sign and date. The old form (CMS Form #5201.5; dated *3/2010*) does not have a section to document the *time* when the patient signs and dates form to acknowledge having received the notice. The updated form has a revision date of *7/2010*. Since the time was not documented when the patient signed the form, surveyor is unable to determine whether the hospital met the required time frame to inform the patient of their beneficiary notice of non-coverage and right to appeal a premature discharge.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 No consistent method of checks were being performed to ensure beneficiary notice was in the record and consistently being signed within 2 days of discharge.
#2 "Important Message from Medicare" notice was old version, 3/2010. Hospital staff was not aware of new version available.

Organization Corrective Action Plan (CAP): #1 Case management will be responsible for maintaining a new form (QI.F.001.00) to monitor "Important Message" and "Advance Directives" to ensure signage at admission, initiated by registration clerks, and before discharge and if follow-up is required. We also will revise our process to have observation patients sign the important Message to Medicare Patients in an effort to not miss weekend patients and those patients changed from observation to inpatient.
#2 "Important Message from Medicare" notice has been replaced with the most recent approved version, 7/2010, to document time. Director has signed up to receive e-alerts from the CMS website. Registration and admission clerks/personnel are being trained/educated on completion of the newest form.

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Person/Function responsible for implementation of Corrective Action Plan:	Michelle Simpson, Judy King, Denise Nichols, Cheryl Manns CNO/Quality Case Mgmt, Case Mgmt, HIM Director
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly UR meetings to monitor utilization review in addition to meeting requirements of new form with Important Message (IM) and Adv.Directives (AD). Quality data will be entered monthly for number of IM and AD.
DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: 9/17/15	***DNV GL reviewer:* P. Horine**
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.***
- ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.***

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OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].

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Survey Report and Corrective Action Plan Submittal Form

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Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-6	**Patient Rights** Specific Rights (Pain Management)	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**PR.1 (SR.11)** *ISO 9001:2008;7.2.1*	

Requirement (Description):

PR.1 SPECIFIC RIGHTS

The CAH shall inform, whenever possible, each patient and/or legal representative of the patient's rights in advance of providing or discontinuing care. The written listing of these rights shall be provided to the patient and /or family and shall include policies and procedures that address the following:

SR.11 Pain Management

ISO 9001:2008; 7.2.1 Determination of requirements related to the product

The organization shall determine
a) requirements specified by the customer, including the requirements for delivery and post-delivery activities,
b) requirements not stated by the customer but necessary for specified or intended use, where known,
c) statutory and regulatory requirements applicable to the product, and
d) any additional requirements considered necessary by the organization.

The requirement was NOT MET as evidenced by the following:

Finding #1: Hospital Policy
Per hospital policy, the pain goal is to be developed related to patient's ability to function and activities of daily living. There is a section in the electronic medical record to document this. Hospital policy is not being following related to this requirement (see MR #1, #2, #3, #4, #6, #7 & #20).

Reference: Lauderdale Community Hospital policy #PC.S.015.05, "Pain Management," Revised 3/2015

Finding #2: Medical Records
In seven (7) of seven (7) medical records reviewed related to pain management, the following was identified:

a. MR #1: Patient presented with chest pain and stated pain level at "5" (0-10 numeric scale). Nurses interviewed stated that pain reassessment occurs within one hour *after* pain intervention. Patient was medicated at 0420 and 0434. Pain was reassessed greater than one hour after intervention at 0555.
b. MR #6: 7/28/2015 at 0855- Patient was medicated for pain. No pain assessment was documented prior to intervention
c. MR #20: 9/25/2015 at 1637- Patient was medicated for pain. No documentation of pain assessment *prior* to or pain reassessment *after* intervention.

Hospital policy does not address a certain time frame for pain reassessment after an intervention. However, each nurse who was interviewed articulated that reassessment occurs within one hour *after* an intervention.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Pain goal is not being documented in the EMR per hospital policy. Nursing inadvertently skips this at times due to not having a "hard stop" which requires this to be documented.
#2 Nurses are not documenting pain assessment and reassessment consistently due to not having a "hard stop" to document prior to and after pain medications. There is a way to document this in the EMR, but this "Action Queue" is also used by so many other processes that it does not indicate which event needs documenting or doing without going through a long process.

Organization Corrective Action Plan (CAP): #1 EMR provider is going to be contacted to see if they can produce a

"hard stop" on the pain goal to ensure consistency in evaluating the goal of pain for a patient. Education will be provided to the nursing staff. If no improvement in documentation, will implement pain assess/reassess form in paper version. #2 Nurses will be re-educated during upcoming staff meetings to document pain assessment and reassessment and an attempt will be made to require a reassessment for "effectiveness of medication" in the EMR. If no improvement in documentation, will implement pain assess/reassess form in paper version.	
Person/Function responsible for implementation of Corrective Action Plan:	Heather Fowlkes, RN Specialist/Educator; Cassandra Williams Nurse Manager; Judy King MS supv
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Pain assessment and reassessment will be reviewed and educated to nursing staff during staff meetings on Aug 30, sept 1-3. ED Nurse Manager and Clinical Educator will review records for next 2 months to indicate whether training has been effective in pain assessment and reassessment. If no improvement in documentation, will implement pain assess/reassess form in paper version.
DNV GL- HEALTHCARE USE ONLY	
***CAP accepted date:* 9/15/15**	***DNV GL reviewer:* jlds** **DNV GL NOTE:** The policy revision is not outlined in the corrective action submitted and needs to be part of the internal CAP. This will be reviewed in detail at the next on site survey. "Hospital policy does not address a certain time frame for pain reassessment after an intervention. However, each nurse who was interviewed articulated that reassessment occurs within one hour *after* an intervention."
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***
DNV GL final follow-up and closure of NC: ***DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:*** - ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.*** - ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.*** ***This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.***	
OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE	
General instructions: *See instructions under NC-1-1 above.* ***DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does***	

not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.
Submitted by:
Submission date:
Objective evidence summary: *[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].*

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DNV·GL

Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-7	**Patient Rights** Advance Directives	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**PR.2 (SR.1) / (SR.5)** *ISO 9001:2008;7.5.1*	

Requirement (Description):

PR.2 ADVANCE DIRECTIVE

The CAH must allow the patient to formulate advance directives and to have CAH staff and practitioners comply with the advance directives in accordance with Federal and State law, rules and regulations.

SR.1 The CAH shall document in the patient's medical record whether or not the patient has executed an advance directive.

SR.5 When the advance directive exists and is not in the patient's medical record, a written policy for follow-up and compliance shall exist.

Interpretive Guidelines:

The CAH must document in a prominent part of the patient's medical record whether or not the patient has executed an advance directive.

The CAH must not condition the provision of care or otherwise discriminate against an individual on the basis of whether or not the patient has executed an advance directive.

The CAH must ensure compliance with State law regarding the provision of an advance directive and inform individuals that complaints concerning the advance directive requirements may be filed with the State survey agency and this accreditation body.
When the advance directive exists and is not in the patient's medical record, a written policy must be in place to address the follow-up and compliance. When necessary, the CAH will take the appropriate steps to secure a copy of the patient's advance directives.

ISO 9001:2008;7.5.1 Control of production and service provision

The organization shall plan and carry out production and service provision under controlled conditions. Controlled conditions shall include, as applicable,
a) the availability of information that describes the characteristics of the product,
b) the availability of work instructions, as necessary,
c) the use of suitable equipment,
d) the availability and use of monitoring and measuring equipment,
e) the implementation of monitoring and measurement, and
f) the implementation of product release, delivery and post-delivery activities.

The requirement was NOT MET as evidenced by the following:

Finding #1: Hospital Policy
Hospital policy does not address or outline the follow-up and compliance process per standards. Nurses were unable to articulate the process to follow when patients indicate that they have an advance directive but is not with them upon presentation to hospital.

Reference: Lauderdale Community Hospital, "Advance Directive," Reviewed 10/2014

Finding #2: Medical Records
In four (4) of six (6) medical records reviewed related to the advance directives process, the following was identified:

a. MR#2: Patient and Registrar signed and dated the "Patient Self-Determination Form" but did not complete the information required. Unable to determine whether he or she was in possession of an advance directive.
b. MR#4, #6: Patient was admitted on 7/10/2015 and 7/23/2015, respectively. Upon admission, it was documented that the patient had an advance directive but was not brought to the hospital. The staff requested the family to bring in a copy of the advance directive. However, there was no further documentation of attempts to secure a copy for the medical record by the date record was reviewed (on 7/28/2015).
c. MR #9: It was documented upon admission that the patient had a copy of their advance directive "on file." However, unable to locate a copy in the medical record.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Hospital policy does not address follow-up on advance directives.
#2 Nursing relies on clerks to ask for advance directives and obtain a copy if required. No follow-up for placement of advanced directives (AD) copy has been educated to the nurses one on one; therefore, there was inconsistent documentation of follow-up.

Organization Corrective Action Plan (CAP): #1 Hospital policy will be revised to include follow up process on AD.
#2: Clerks will be educated to input "priority note" on pt notes sidebar to obtain AD. Charge nurses are to be educated to follow up on placement of AD copy to chart and document efforts in chart. We have a new form that case management will own (#QI.F.001.00) that has a check-box to follow up on AD and check if AD copy is in the chart.

Person/Function responsible for implementation of Corrective Action Plan:	Cassandra Williams, Judy King, Denise Nichols, Heather Fowlkes Nurse manager Case mgmt Case mgmt Clinical Educator
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly UR meetings to monitor utilization review in addition to meeting requirements of new form with Important Message (IM) and Adv.Directives (AD). Chart review of quality data will be entered monthly for number of IM and AD.

DNV GL- HEALTHCARE USE ONLY

***CAP accepted date:* 9/15/15**	***DNV GL reviewer:* jlds** **DNV GL NOTE:** The education for the policy revision is not outlined in the corrective action submitted and needs to be part of the internal CAP. This will be reviewed in detail at the next on site survey.
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.***
- ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.***

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

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General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:
Submission date:
Objective evidence summary:
[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].

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Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-8	**Physical Environment** Life Safety Management	☐ NC-1 Condition-level ☑ NC-1 ☐ NC-2	**PE.2 (SR.1) / (SR.3) / (SR.3a-3h) / (SR.6) / (SR.6a(1)) / (SR.8)** **PE.1 (SR.3) / (SR.4)** *NFPA 13-1999;6-1.1.5,A-1.1.5* *NFPA 25-1998;3-3.1.1* *NFPA 72-1999;7-3.2* *NFPA 80-1999;19.4* *NFPA 90A-1999;3-4.7* *NFPA 101-2000;7.9.3,7.2.1.1.1,7.2.1.1.2,7.2.1.5.1,7.2.1.7.1,7.2.1.7.2,7.2.1.7.3,8.2.3.2.4.2,19.2.1* *ISO 9001:2008;6.3* *ISO 9001:2008;6.4*	485.623(d)(1)(i)

Requirement (Description):

PE.2 LIFE SAFETY MANAGEMENT

SR.1 The CAH shall meet the applicable provisions of the 2000 edition of the Life Safety Code® of the National Fire Protection Association.

SR.3 The CAH must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing
fires; protection of patients, personnel and guests; evacuation; and cooperation with firefighting and emergency management authorities; including training of staff in the following areas:

The fire control plan shall provide for the following (NFPA 101-2000, 18.7.2.2 & 19.7.2.2):

SR.3a Use of alarms
SR.3b Transmission of alarm to fire department
SR.3c Response to alarms
SR.3d Isolation of fire
SR.3e Evacuation of immediate area
SR.3f Evacuation of smoke compartment
SR.3g Preparation of floors and building for evacuation
SR.3h Extinguishment of fire

SR.6 Health care occupancies shall conduct unannounced fire drills, but not less than one (1) drill per shift per calendar quarter that transmits a fire alarm signal and simulates an emergency fire condition. When fire drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. (NFPA 101-2000, 18.7.1.2. & 19.7.1.2). False alarms may be used (up to 50% of total drills) if all elements of the fire plan are exercised.

Business occupancies shall conduct at least one unannounced fire drill annually per shift.

SR.6a Fire drills must be thoroughly documented and evaluate the CAH's knowledge to the items listed in PE.2, SR.3

SR.6a(1) At least annually, the CAH shall evaluate the effectiveness of the fire drills, The report of effectiveness shall be forwarded to Quality Management oversight

SR.8 The CAH shall require that Life Safety systems (e.g., fire suppression, notification, and detection equipment) shall be tested and inspected (including portable systems).

PE.1 FACILITY

The facility shall be constructed, arranged, and maintained to ensure patient safety, and to provide adequate space and will be appropriate for the services provided.

SR.3 The CAH shall have a process in place, as required and/or recommended by local, State, and national authorities or related professional CAHs, to maintain a safe environment for the CAH's patients, staff, and others.

SR.4 The CAH shall have a written policies and procedures to define how unfavorable occurrences, incidents, or impairments in the facility's infrastructure, Life Safety, Safety, Security, Hazardous Material/Waste, Emergency, Medical Equipment, and Utilities Management are prevented, controlled, investigated, and reported throughout the CAH.

Finding #3
NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 3-3.1.1 *A flow test shall be conducted at the hydraulically most remote hose connection of each zone of a standpipe system to verify the water supply still adequately provides the designed pressure at the required flow. Where a flow test of the hydraulically most remote outlet(s) is not practical, the authority having jurisdiction shall be consulted for the appropriate location for the test. A flow test shall be conducted every 5 years.*

Finding #4
NFPA 72, National Fire Alarm Code, 1999 Edition 7-3.2 Testing*. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit specifically listed for the application, the manual testing frequency shall be permitted to be extended to annual. Table 7-3.2 shall apply.*

Finding #6
NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 1999 Edition 3-4.7 Maintenance. *At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary.*

Surveyor Note: Per CMMS S & C Memo 10-04-LSC a hospital may elect to inspect dampers in healthcare occupancies every 6 years in accordance with the 2007 edition of NFPA 80 and NFPA 105.

NFPA 80, Standard for Fire Doors and Other Opening Protections 19.4 *Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.*

Finding #7
NFPA 101, Life Safety Code, 2000 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment. *A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than $1^1/_2$ hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.*

Finding #8
NFPA 101, Life Safety Code-2000 Edition 7.2.1.1.1 *A door assembly in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.1. Such an assembly shall be designated as a door.*
7.2.1.1.2 *Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct. Windows that, because of their physical configuration or design and the materials used in their construction, have the potential to be mistaken for doors shall be made inaccessible to the occupants by barriers or railings.*
7.2.1.5.1 *Doors shall be arranged to be opened readily from the egress side whenever the building is*

occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.

7.2.1.7.1 *Where a door is required to be equipped with panic or fire exit hardware, such hardware shall meet the following criteria:*

(1)It shall consist of cross bars or push pads, the actuating portion of which extends across not less than one-half of the width of the door leaf and not less than 34 in. (86 cm), nor not more than 48 in. (122 cm), above the floor.

Exception: Existing installations shall be permitted to be minimum 30 in. (76 cm) above the floor.

(2)It shall be constructed so that a horizontal force not to exceed 15 lb. (66 N) actuates the cross bar or push pad and latches.

7.2.1.7.2 *Only approved panic hardware shall be used on doors that are not fire doors. Only approved fire exit hardware shall be used on fire doors.*

7.2.1.7.3

19.2.1 General. *Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.*

Finding #9

NFPA 101, Life Safety Code, 2000 Edition

8.2.3.2.4.2 *Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:*

(1) *The space between the penetrating item and the fire barrier shall meet one of the following conditions:*
   a. *It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.*
   b. *It shall be protected by an approved device that is designed for the specific purpose.*

(2) *Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:*
   a. *It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.*
   b. *It shall be protected by an approved device that is designed for the specific purpose.*

(3) **Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:*
   a. *The material shall be capable of maintaining the fire resistance of the fire barrier.*
   b. *The material shall be protected by an approved device that is designed for the specific purpose.*

(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:
   a. It shall be made on either side of the fire barrier.
   b. It shall be made by an approved device that is designed for the specific purpose.

Finding #10

NFPA 13, Standard for the Installation of Sprinkler Systems, 1999 Edition.

6-1.1.5 *Sprinkler piping or hangers shall not be used to support non-system components.*

A-1.1.5 *The rules covering the hanging of sprinkler piping take into consideration the weight of water-filled pipes plus a safety factor. No allowance has been made for the hanging of non-system components from sprinkler piping.*

Finding #11

NFPA 101, Life Safety Code, 2000 Edition

7.2.1.1.1 *A door assembly in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.1. Such an assembly shall be designated as a door.*

7.2.1.1.2 *Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct. Windows that, because of their physical configuration or design and the materials used in their construction, have the potential to be mistaken for doors shall be made inaccessible to the occupants by barriers or railings.*

7.2.1.5.1 *Doors shall be arranged to be opened readily from the egress side whenever the building is*

occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.

7.2.1.7.1 *Where a door is required to be equipped with panic or fire exit hardware, such hardware shall meet the following criteria:*

(1)It shall consist of cross bars or push pads, the actuating portion of which extends across not less than one-half of the width of the door leaf and not less than 34 in. (86 cm), nor not more than 48 in. (122 cm), above the floor.

Exception: Existing installations shall be permitted to be minimum 30 in. (76 cm) above the floor.

(2)It shall be constructed so that a horizontal force not to exceed 15 lb. (66 N) actuates the cross bar or push pad and latches.

7.2.1.7.2 *Only approved panic hardware shall be used on doors that are not fire doors. Only approved fire exit hardware shall be used on fire doors.*

7.2.1.7.3

19.2.1 General. *Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.*

ISO 9001:2008;6.3 Infrastructure

The organization shall determine, provide and maintain the infrastructure needed to achieve conformity to product requirements. Infrastructure includes, as applicable,
a) buildings, workspace and associated utilities,
b) process equipment (both hardware and software), and
c) supporting services (such as transport, communication or information systems).

ISO 9001:2008;6.4 Work environment

The organization shall determine and manage the work environment needed to achieve conformity to product requirements.

NOTE: The term "work environment" relates to those conditions under which work is performed including physical, environmental and other factors (such as noise, temperature, humidity, lighting or weather).

The requirement was NOT MET as evidenced by the following:

Finding #1
During the physical environment document review with Hospital Staff the surveyor noted that the Hospital does not have a Barrier Protection Plan to provide for the isolation of possible fire.

Finding #2
During the physical environment document review with Hospital Staff the surveyor noted the hospital still lacks objective evidence of an annual evaluation of the fire drills.
Surveyor note: This is a repeat finding from last year's survey, NC-2-13.

Finding #3
During the physical environment document review with Hospital Staff the surveyor noted there is no objective evidence the hospital has completed the 5 year standpipe flow test for the fire sprinkler system.

Finding #4
During the physical environment document review with Hospital Staff the surveyor noted there is no objective evidence the hospital conducted a quarterly fire sprinkler system inspection for the 2nd quarter of 2015. This inspection includes Supervisory Signal Devices, Emergency Services Notification Transmission Equipment, Fire department Connections and water flow and tamper switch inspections/testing.

Finding #5

During the physical environment document review with Hospital Staff the surveyor noted on the Townsend Systems Annual Fire Equipment Inspection Report completed 5/21/2015 4 horn/strobes failed testing, 2 Duct Detectors failed testing and the smoke detectors in AHU's 3 & 4 failed testing. There is no objective evidence these discrepancies have been repaired.

Finding #6

During the physical environment document review with Hospital Staff the surveyor noted there is no objective evidence the hospital has completed the 6 year fire/smoke damper inspections/testing for the hospital 's fire/smoke dampers.

Finding #7

During the physical environment document review with Hospital Staff the surveyor noted the last annual testing of the hospital's battery backup emergency egress lights was conducted in February of 2014. This testing is required to be completed every 12 months and the hospital is 5 months overdue as of the date of this survey.

Finding #8

During the physical environment document review with Hospital Staff the surveyor noted on the Hospital's Fire and Smoke Door Inspection Report dated 4/14/2015 there are 7 doors that are missing either top or bottom latching hardware. There is no objective evidence these Fire/Smoke doors have been repaired.

Finding #9

During the physical environment building tour with Hospital Staff the surveyor noted Fire/Smoke wall penetrations in the following locations:

1. P/T Unit Corridor at 1 hour Smoke Barrier Wall-One penetration
2. Med/Surg Corridor at 1 hour Smoke Barrier Wall-2 penetrations

Finding #10

During the physical environment building tour with Hospital Staff the surveyor noted Equipment/cables/wires hanging off of the Fire Sprinkler Lines in the following locations:

1. P/T Unit Corridor-Fixed electrical conduit wired to sprinkler lines, Communication Cables, and 4 insulated water pipes lying on top of the fire sprinkler line.
2. Med/Surg Corridor-Communication Cables, wires and flexible conduit

Lauderdale Community Hospital Policy SF.035.001, Automatic Sprinkler System, states that " nothing should be supported by the pipes in the Automatic Sprinkler System".

Finding #11

During the physical environment building tour with Hospital Staff the surveyor noted the entrance/exit door at the ED Registration counter contains a mechanical latch operated by a key in the path of egress. When the latch is engaged, there is no egress from the hospital through this door. The door is noted on the Architectural Drawings as a main egress pathway out of the hospital and is mark with an exit sign over the door.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Plant Operations did not have a Barrier Protection Plan.
#2 Safety Officer thought the 2014 summary with the Quality Lead was objective evidence of annual evaluation.
#3 LCH does not have a fire hose connector to the hospital for standpipe flow test.
#4 Employee change-over at "Superior" caused the July 1st quarterly fire sprinkler inspection to be missed. They arrived on July 30th.
#5 Failed testing discrepancies had not been repaired due to funding and Townsend refusal to come out until completely pd off.
#6 6 year inspections/testing for fire/smoke damper had not been performed due to waiting on contract to be signed.
#7 23 emergency lights testing to be completed every 12 months was late due to process change and documentation.
#8 7 doors missing either top or bottom latching hardware not repaired due to one of the two were in working order and LCH previously understood only one had to work since very expensive to replace.
#9 Penetrations in P/T and Med/Surg were unknown by LCH plant operations.
#10 Lines and pipes hanging off the sprinker lines not recognized by plant operations.
#11 Main egress door contained a keyed lock instead of push to exit.

Organization Corrective Action Plan (CAP): #1 New policy has been created for the Barrier Protection Plan.

#2 New plan to take fire drills to safety committee, and on the MSQI and board. (Done at Safety meeting Aug 20, 2015).
#3 New letter from Fire Chief explaining that we do not have fire/water hose hook-up for standpipe flow test.
#4 Superior came on July 30th to perform the quarterly fire sprinkler system inspection.
#5 Work order has been turned in for Townsend to repair discrepancies in failed testing. Accounts payable have been notified to get this account paid in order for the work to be performed.
#6 Our staff is going to training to inspect the fire/smoke dampers as evidenced by NFPA 80 (Chap 19) and NFPA 105 (chap 5,6,7). Maintenance records to be kept. Dampers to be numbered with established location, picture with closed and open and will repair as needed.
#7 23 emergency lights with batteries to be replaced annually (8 have already been replaced and will replace the rest upon arrival).
#8 Latching doors – quotes will be obtained to repair/replace the hardware for each door (at least 2 doors at a time) until all complete.
#9 Penetrations have already been repaired in P/T and Med/Surg locations.
#10 Cables/wires hanging off Fire sprinkler lines: all will be pulled up/off during damper maintenance expected to occur by ~~Oct 11, 2015~~.
UPDATE 9/22/2015 mns – occur by September 27, 2015
UPDATE 9/24/2015 mns – Cables/wires hanging off Fire sprinkler lines: all will be pulled off during damper maintenance and plan to perform 30 per month until complete – implementing September 24, 2015
#11 Exit Door lock has already been disabled on 8/13/2015.

Person/Function responsible for implementation of Corrective Action Plan:	Curt Langley – Plant Operations director
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ UPDATE 9/22/2015 mns – September 27, 2015 **UPDATE 9/24/2015 mns – September 24, 2015**
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly log is maintained in Life safety book for quarterly fire sprinkler system, failed testing, fire/smoke dampers, and emergency lighting.
DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: **Findings# 1, #2, #4,#9,#11 09/15/2015** **Findings #5,#6,#7,#8,#10 10/15/2015**	***DNV GL reviewer:*** **R.Snelling** **R. Snelling, CPEO**
Clarification requested date: **09/15/2015**	***DNV GL reviewer:*** **R.Snelling**

Clarification request:

Finding #3: Fire Chief documentation needed for CAP completion. Please submit.

Findings #5,#6,#7,#8,#10
The corrective actions for these six findings must be completed within 60 days of the last day of the survey. This date is September 27, 2015. If these actions cannot be completed by this date the hospital may request a CMS-approved time extended waiver through DNV GL-Healthcare.
(Please see attached documentation on requests for CMS- approved time extended waivers)

- If the CAP will be implemented by this date, please submit an update to the CAP in the above applicable ***ORGANIZATION RESPONSE SECTION***. Preface the updated documentation with **UPDATE xx/xx/2015**

- If the CAP will not be implemented by this date, initiate the LSC waivers or Fire Safety Evaluation System (FSES) equivalencies below.

Updated documents submitted by client:

LauderdaleCommunityHospital 7825.pdf

TOWNSEND CK 10-6-15.pdf

quote.pdf

FW pod townsend check.msg

Date CAP verified effective/closed:	***DNV GL reviewer:***

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- ***Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.***
- ***High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.***

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

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General instructions: *See instructions under NC-1-1 above.* ***DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.***
Submitted by:
Submission date:
Objective evidence summary: *[Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1].*

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Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-1	**Infection Control** Infection Control System	☐ NC-1 Condition-level ☐ NC-1 ☑ NC-2	**IC.1 (SR.1,6)** *ISO 9001:2008;6.4* *ISO 9001;2008;8.3*	485.623(c)(4) 485.635(a)(3)(vi)

Requirement (Description):

IC.1 INFECTION PREVENTION AND CONTROL SYSTEM

SR.1 The CAH shall have a process in place, as required and/or recommended by the Centers for Disease Control (CDC) and related professional CAHs, to maintain a sanitary environment for CAH patients, staff, and others. This process shall provide the means for avoiding and transmitting infections and communicable diseases.

SR.6 The CAH, through its individual who assumes full legal authority and responsibility for operations of the CAH, Medical Director and nurse executive/leader shall ensure that the Infection Control System and associated activities adequately address issues identified throughout the CAH and there are prevention, correction, improvement and training programs to address these issues and provide adequate resources to accomplish the associated activities of the infection control program,.

Interpretive Guidelines:

The CAH must maintain an infection control program for the prevention, control, and surveillance of infections (which includes, but is not limited to nosocomial infections) and communicable diseases of patients and personnel (which includes, but is not limited to patient care staff).

The infection control surveillance program will include specific measures for prevention, detection, control, intervention, education, collection of data and investigation of infections and communicable diseases in the CAH that covers patients and CAH staff. The infection control program must be continually evaluated for effectiveness and when necessary, corrective and/or preventive action taken to reduce risks of infections. The infection control program will encompass nationally recognized systems of infection control guidelines to reduce the risk and transmission of infections and communicable diseases (e.g., the Centers for Disease Control and Prevention (CDC) Guidelines for Prevention and Control of Nosocomial Infections, the CDC Guidelines for Preventing the Transmission of Tuberculosis in Health Care Facilities, the Society for Healthcare Epidemiology of America (SHEA), the Association of periOperative Registered Nurses (AORN), the Occupational Health and Safety Administration (OSHA) regulations, and the Association for Professionals in Infection Control and Epidemiology (APIC) infection control guidelines).

The CAH must provide for and maintain a sanitary environment to avoid the sources and transmission of infections and communicable diseases. All areas of the CAH must be regularly cleaned and sanitary including all CAH units, campuses and off-site locations (as applicable). The infection control surveillance program will include monitoring of housekeeping and maintenance (including when applicable areas of the CAH are under repair, renovation or construction) as well as any other activities to ensure the CAH maintains a sanitary environment.

The CAH shall have a documented process, policies and procedures to define how infections and communicable diseases are prevented, controlled and investigated throughout the CAH. These policies and procedures will include:

- *Mitigation of risks associated with patient infections present upon admissions to include:*
  - *Early identification of patients who require isolation and techniques for precaution in accordance with CDC guidelines*
  - *Appropriate use of personal protective equipment (i.e. gowns, masks, gloves, eye protection)*
- *The CAH leaders are responsible for implementing and ensuring corrective/preventive action(s) are implemented and effective in addressing infection control issues.*

- *A process for identifying, reporting, investigating preventing, controlling infections and communicable diseases; to include both inpatient and outpatient populations as well as CAH staff;*

- *A process for adequately addressing issues identified throughout the CAH and for the prevention, correction, improvement and training programs to address these issues;*

The chief executive officer (Color individual who assumes full legal authority and responsibility for operations of the CAH), the medical staff and the nurse executive/leader, must ensure that the CAH-wide quality management oversight and staff in-service training programs address problems identified through the infection control program.

The chief executive officer (CEO, or individual who assumes full legal authority and responsibility for operations of the CAH), the medical staff, and the nurse executive/leader are responsible for implementing corrective action plans to address problems identified by the infection control officer(s). These plans should be evaluated for effectiveness and revised if needed, and documentation concerning corrective actions and outcomes should be maintained.

ISO 9001:2008;6.4 Work environment

The organization shall determine and manage the work environment needed to achieve conformity to product requirements.

NOTE: The term "work environment" relates to those conditions under which work is performed including physical, environmental and other factors (such as noise, temperature, humidity, lighting or weather).

ISO 9001;2008;8.3 Control of nonconforming product

The organization shall ensure that product which does not conform to product requirements is identified and controlled to prevent its unintended use or delivery. A documented procedure shall be established to define the controls and related responsibilities and authorities for dealing with nonconforming product.

Where applicable, the organization shall deal with nonconforming product by one or more of the following ways:
a) by taking action to eliminate the detected nonconformity;
b) by authorizing its use, release or acceptance under concession by a relevant authority and, where applicable, by the customer;
c) by taking action to preclude its original intended use or application;
d) by taking action appropriate to the effects, or potential effects, of the nonconformity when nonconforming product is detected after delivery or use has started.

When nonconforming product is corrected it shall be subject to re-verification to demonstrate conformity to the requirements.

Records of the nature of nonconformities and any subsequent actions taken, including concessions obtained, shall be maintained (see 4.2.4).

The requirement was NOT MET as evidenced by the following:

During survey activity, the following items were identified:

Finding #1: Nonconforming Products/Outdated Supplies

a. Medical-Surgical:
   1) Crash cart: Shiley trach tubes size 6 (1 box) expired 3/2015

b. Emergency Department:
   1) Fast track: Culture swabs (x2) expired 5/2015
   2) Supply room: Ice machine- grate had rusted areas and white-colored deposits; per staff, machine is old and difficult to clean

Finding #2: Clean Equipment

a. Process to identify and store clean equipment: Per staff, cleaned equipment are either covered with plastic bag (if able to fit) or have an orange tape applied. In soiled utility room, it was identified that these are

dirty and therefore, do not have an orange sticker. However, in medical-surgical unit's clean supply room, bedside commodes were stored *without* either a plastic bag or orange sticker, yet were noted to be in the clean supply room. Staff were unable to identify reason for inconsistency in process.

Finding #3: Equipment Set-up
Emergency Room: Per staff, all rooms are set up with opened packages of suction tubing and Yankauer catheter at bedside. Staff was not expecting an impending patient. Staff was unable to articulate how long supply items have been hanging or number of patients who have been through this area since supplies were originally set up. However, current practice is not to discard these supplies until they have been used. Staff acknowledged that it could be weeks or a month(s) before supplies are used. There were visible layers of dust on equipment. These pose an infection control risk.

Finding #4: Fans
Stand-up fans are being utilized in patient rooms in Medical-Surgical and Emergency Departments. Per staff, there is no documented process to clean/sterilize these fans in between use on each patient. Facilities department is called to clean the fans when the blades are visibly dirty. Fans that were located in room #4 in the Emergency Department and inpatient unit were visibly dusty but were still available for patient use. Current practice poses an infection risk.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1a1 LCH did not have any other trach tubes to replace expired box due to funding; #1b1 Culture swabs were pulled from all rooms, so did not know to check for expired supplies in that room.
#1b2 Ice Machine with rusted areas and white deposits due to machine being old and difficult to clean.
#2 No consistent process house-wide for bedside commodes noted to be visually clean. ER has orange stickers/MS did not.
#3 Visible dust on suction equipment: Staff always felt more in control with supplies "ready" when needed than having to pull together supplies and connect in an emergency situation.
#4 Visible dust on fans. IC risk. No documented process to clean between patients.

Organization Corrective Action Plan (CAP): #1a1 Pull expired supplies out of crash cart unless have a manufacturer's recommendation to use as a non-conforming product. #1b1 Check all rooms for any expired supplies regardless if supposed to be in the room or not. #1b2 Recommendations to repaint ice machine or until able to buy a new ice machine.
#2 New process house-wide to use orange stickers on bedside commodes. ADD to safety rounds to check and ensure compliance followed.
#3 Process change to make a "cook bag" to bag up all suction supplies together to keep equipment "clean" before use.
#4 Recommend to IC to clean between patients and to terminally clean while taken apart by maintenance after work order completed when visibly dirty. ADD to safety rounds to check and ensure compliance is followed.

Person/Function responsible for implementation of Corrective Action Plan:	Cassandra Williams Nurse manager; Judy King MS supv; Cindy Kidd IC/EH; Curt Langley Plant Operations
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ **UPDATE 9/22/2015 mns – September 27, 2015**
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Safety committee to round in areas and add these processes to monthly checks to ensure follow through and sustained compliance.

DNV GL- HEALTHCARE USE ONLY

***CAP accepted date:* 9/17/15**	***DNV GL reviewer:* P. Horine**
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***
DNV GL final follow-up and closure of NC:	

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Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-2	**Utilization Review** Utilization Review Process	☐ NC-1 Condition-level ☐ NC-1 ☑ NC-2	**UR.1 (SR.2) / (SR.3)** *ISO 9001:2008;7.5.2*	

Requirement (Description):

The CAH shall have a process in place (either directly or through agreement or arrangement) for review and evaluation to ensure appropriate utilization of services provided by the CAH organizational and medical staff services to patients, particularly those patients entitled to benefits under both Medicare and Medicaid.

SR.2 Medical necessity of professional services.

SR.3 Professional services furnished, including medications.

ISO 9001:2008;7.5.2 Validation of processes for production and service provision
The organization shall validate any processes for production and service provision where the resulting output cannot be verified by subsequent monitoring or measurement and, as a consequence, deficiencies become apparent only after the product is in use or the service has been delivered.
Validation shall demonstrate the ability of these processes to achieve planned results.
The organization shall establish arrangements for these processes including, as applicable,
a) defined criteria for review and approval of the processes,
b) approval of equipment and qualification of personnel,
c) use of specific methods and procedures,

The requirement was NOT MET as evidenced by the following:

A review of the organization's Utilization Review process revealed that the organization has a written "Utilization Management Plan" (October 2014) that addresses the utilization review function and related processes. In addition to this document, it was identified that the medical staff by-laws (Revision 2015) also address the unitization review function and related processes. Review of UR records/documents and through interviews with UR staff it was determined that the organization does not consistently follow its' own requirements. Additionally, it was noted that the UR Plan (October 2014) and medical staff by-laws (revision 2015) are not in concert.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: Utilization Management Plan and Bylaws are not consistent.

Organization Corrective Action Plan (CAP): Quality/CNO and Risk Manager to compare and unite processes to be consistent. UR to meet monthly through MSQI.

Person/Function responsible for implementation of Corrective Action Plan:	Michelle Simpson, CNO/Quality; Cheryl Manns, Risk
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ **UPDATE 9/22/2015 mns – September 27, 2015**
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Place on MPRC agenda to review annually by placing into Patient Care policies and combining all 3 policies re: utilization review if possible. UR to meet monthly through MSQI.

DNV GL- HEALTHCARE USE ONLY

***CAP accepted date:* 9/15/15**	***DNV GL reviewer:* jlds**
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***
DNV GL final follow-up and closure of NC:	

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Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-3	**Patient Rights** Grievance Procedure	☐ NC-1 Condition-level ☐ NC-1 ☑ NC-2	**PR.5 (SR.2) / (SR.3) / (SR.4)** *ISO 9001:2008;7.2.3*	

Requirement (Description):

The CAH shall develop and implement a formal grievance procedure that provides for the following:

SR.2 The governing body's review and resolution of grievances or the written delegation of this function to an appropriate person or committee;

SR.3 A referral process for quality of care issues to the Utilization Review, Quality Management or Peer Review functions, as appropriate; and,

SR.4 Specification of reasonable timeframes for review and response to grievance

Interpretive Guideline:

The CAH must develop and implement a formal grievance procedure to identify the process that will be followed and the required correspondence, including grievance resolution, to be provided to the patient.

Definition elements: A "patient grievance" is a formal or informal written or verbal complaint that is made to the CAH by a patient, or the patient's representative, when a patient issue cannot be resolved promptly by staff present. If a complaint cannot be resolved promptly by staff present or is referred to a complaint coordinator, patient advocate, or CAH management, it is to be considered a grievance.

ISO 9001:2008 7.2.3 Customer communication

The organization shall determine and implement effective arrangements for communicating with customers in relation to
a) product information,
b) enquiries, contracts or order handling, including amendments, and
c) customer feedback, including customer complaints.

The requirement was NOT MET as evidenced by the following:

During the review of the patient grievance process it was noted that the organization does not clearly define the difference between a complaint and a formal grievance. The policy, "Patient Resolution of Complaints" (10/14) has definitions of grievance with potential harm and grievances without potential harm. The policy does not identify when a complaint can be elevated to grievance status. The organization's established time frame for resolving grievances is 2-5 days. A review of the grievance log revealed that this time frame is not being met. It was noted that most of the grievances are generated in the ED and this information is forwarded to the ED medical director who is only available every three months which at times impacts resolution time frames.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: Organization did not define complaint and grievance as easily understood. The policy does not clearly identify when a complaint can be elevated to grievance status. Time frame of 2-5 days is not being met.

Organization Corrective Action Plan (CAP): Policy to be revised to define complaint and grievance into easily understood terms. Policy to identify when a complaint can be elevated to grievance status. Time frame to be reviewed and revised to meet guidelines.

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Person/Function responsible for implementation of Corrective Action Plan:	Cheryl Manns, Risk Management Director
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ **UPDATE 9/22/2015 mns – September 27, 2015**
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Policy to go to Multidisciplinary Policy Review Council (MPRC) with revisions and will be reviewed annually.
DNV GL- HEALTHCARE USE ONLY	
***CAP accepted date:* 9/15/15**	***DNV GL reviewer:* jlds** **DNV GL NOTE:** The the corrective action submitted addresses a policy revision and the method for follow up follows the policy revision only; however, the method for follow up should address audits for compliance with the new process/procedure/policy. This needs to be part of the internal CAP. This will be reviewed in detail at the next on site survey.
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***
DNV GL final follow-up and closure of NC:	

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Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-4	**Physical Environment** Safety Management	☐ NC-1 Condition-level ☐ NC-1 ☑ NC-2	**PE.3(SR.1) / (SR.2) / (SR.3) / (SR.4)** *NFPA 99-1999;3-3.3.4.2,4-3.5.2.1,8-3.1.11.2* *OSHA 29 CFR 1910.303* *DOT 49 CFR 172.704* *ISO 9001:2008;6.3* *ISO 9001:2008;6.4*	485.623(b)

Requirement (Description):

PE.3 SAFETY MANAGEMENT

SR.1 The CAH shall have processes in place to maintain safe and adequate facilities for its services. Diagnostic and therapeutic facilities must be located for the safety of patients.

SR.2 The CAH shall require that facilities, supplies, and equipment be maintained and ensure an acceptable level of safety and quality. The extent and complexity of facilities shall be determined by the services offered. 485.623(c)(4)

SR.3 The CAH shall require proper ventilation, light and temperature controls in pharmaceutical, food preparation, and other appropriate areas. 485.623(b)(5)

SR.4 The CAH shall maintain an environment free of hazards and manages staff activities to reduce the risk of occupational related illnesses or injuries.

Finding #1
NFPA 99, Standard for Health Care Facilities, 1999 Edition
3-3.3.4.2 *Line Isolation Monitor Tests. The proper functioning of each line isolation monitor (LIM) circuit shall be ensured by the following:*

a) The LIM circuit shall be tested after installation, and prior to being placed in service, by successively grounding each line of the energized distribution system through a resistor of 200 X V ohms, where V = measured line voltage. The visual and audible alarms [see 3-3.2.2.3(b)] shall be activated.

(b) The LIM circuit shall be tested at intervals of not more than 1 month by actuating the LIM test switch [see 3-3.2.2.3(f)]. For a LIM circuit with automated self-test and self-calibration capabilities, this test shall be performed at intervals of not more than 12 months. Actuation of the test switch shall activate both visual and audible alarm indicators.

(c) After any repair or renovation to an electrical distribution system and at intervals of not more than 6 months, the LIM circuit shall be tested in accordance with paragraph (a) above and only when the circuit is not otherwise in use. For a LIM circuit with automated self-test and self-calibration capabilities, this test shall be performed at intervals of not more of not more than 12 months.

Finding #2
OSHA 29 CFR 1910.303
1910.303(b)(1) Examination. Electric equipment shall be free from recognized hazards that are likely to cause death or serious physical harm to employees. Safety of Equipment shall be determined using the following considerations: OSHA 1910.305(j)(1)(iv) Fixtures installed in wet or damp locations shall be identified for purpose and shall be so constructed or installed that water cannot enter or accumulate in a wire way, lamp holders, or other electrical parts.

Finding #3
DOT 49 CFR 172.704

A hazmat employer must train all hazmat employees in general awareness training, function-specific regulatory training, and safety training (e.g., healthcare professionals shall have training to properly use any packaging authorized for the transportation of infectious substances).

Finding #4
NFPA 99, Standard for Health Care Facilities, 1999 Edition
8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3).
(h) *Cylinder or container restraint shall meet 4- 3.5.2.1(b)27.*

4-3.5.2.1 Gases in Cylinders and Liquefied Gases in Containers—Level 1.
(b) Special Precautions — Oxygen Cylinders and Manifolds. Great care shall be exercised in handling oxygen to prevent contact of oxygen under pressure with oils, greases, organic lubricants, rubber, or other materials of an organic nature. The following regulations, based on those of the CGA Pamphlet G-4, Oxygen, shall be observed:

27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.

ISO 9001:2008;6.3 Infrastructure

The organization shall determine, provide and maintain the infrastructure needed to achieve conformity to product requirements. Infrastructure includes, as applicable,
a) buildings, workspace and associated utilities,
b) process equipment (both hardware and software), and
c) supporting services (such as transport, communication or information systems).

ISO 9001:2008; 6.4 Work environment

The organization shall determine and manage the work environment needed to achieve conformity to product requirements.

NOTE: The term "work environment" relates to those conditions under which work is performed including physical, environmental and other factors (such as noise, temperature, humidity, lighting or weather).

The requirement was NOT MET as evidenced by the following:

Finding #1
During the physical environment building tour with hospital staff, the surveyor noted in the Hospital Sleep Lab there is an active Line Isolation Monitor. There is no objective evidence the hospital has conducted the required annual testing on the Line Isolation Monitor.

Finding #2
During the physical environment building tour with hospital staff, the surveyor noted there are 2 active Hydrocollators located in the Physical Therapy Unit that are not plugged into required GFCI electrical outlets.

Finding #3
During the physical environment document review of the Hazardous Materials and Waste Documents with hospital staff, the surveyor noted the staff that sign the Steri-Cycle Manifest for the Bio-Medical Waste transported off the hospital property have not had the required DOT training.

Finding #4
During the physical environment building tour with hospital staff, the surveyor noted in the Mechanical Office there are 3 "H" Cylinders of Medical Air that are not individually chained.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Line was disconnected. LCH did not conduct Line Isolation Monitor on line.
#2 Hydrocollators not plugged into required GFCI electrical outlets.
#3 LCH staff unaware of required DOT training to sign Steri-Cycle manifest.
#4 x3 "H" cylinders not individually chained because staff thought all chained together would be sufficient.

Organization Corrective Action Plan (CAP): #1Will begin testing annually as required.

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#2 Hydrocollators plugged into required GFCI electrical outlets on 7/29/2015. #3 Steri-Cycle video has been requested although they state we have to purchase it before they will give it to us. Will continue to discuss requirements to obtain by ~~October 11, 2015~~. **UPDATE 9/22/2015 mns – by September 27, 2015** #4 3 "H" cylinders chained individually on 7/29/2015.	
Person/Function responsible for implementation of Corrective Action Plan:	Curt Langley, Plant Operations
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ **UPDATE 9/22/2015 mns – September 27, 2015**
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Line isolation monitor will be added to quality annually; Video training to be placed on quality for materials management, plant ops, security, and environmental services employees to view and sign training.
DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: **Findings #2,#3,#4 09/15/2015** **Finding #1 10/15/15**	***DNV GL reviewer:*** **R.Snelling** **R. Snelling, CPEO**
Clarification requested date: **09/15/2015**	***DNV GL reviewer:*** **R.Snelling**
Clarification request: **Finding#1** The corrective actions for this finding must be completed within 60 days of the last day of the survey. This date is September 27, 2015. If these actions cannot be completed by this date the hospital may request a CMS-approved time extended waiver through DNV GL-Healthcare. (Please see attached documentation on requests for CMS- approved time extended waivers) - If the CAP will be implemented by this date, please submit an update to the CAP in the above applicable ***ORGANIZATION RESPONSE SECTION***. Preface the updated documentation with **UPDATE xx/xx/2015** - If the CAP will not be implemented by this date, initiate the LSC waivers or Fire Safety Evaluation System (FSES) equivalencies below.	

FEE FOR ADDITIONAL SERVICES

LSC waivers or Fire Safety Evaluation System (FSES) equivalencies

CMS has implemented a new process to allow hospitals to request a waiver for the Life Safety Code (LSC) or Fire Safety Evaluation System (FSES) equivalencies. This process involves a CMS-required review and recommendation to the CMS Regional Office (RO) by the hospital's CMS-approved Accreditation Organization (AO) after review of documents submitted by the hospital to the AO to support the request. The time for the AO to review documents for a hospital-requested LSC waiver or FSES equivalency determination and submit a written recommendation to the CMS RO is considered an additional service requested by the hospital not covered in our agreement; therefore, DNV GL review of a waiver request or FSES equivalency determination will result in an additional fee. The fee will be charged based on the time spent by DNV GL in reviewing the hospital waiver request and preparing and submitting a written recommendation to the RO. The minimum fee will be one surveyor day ($3,500) and the maximum is not expected to exceed 2 surveyor days ($7,000). In the event the review is expected to involve more time than 2 surveyor days, the hospital will be contacted for written approval before DNV GL begins a review of the hospital's LSC waiver or FSES equivalency request.

Please indicate the hospital's willingness to proceed with a LSC waiver or FSES equivalency request by returning written confirmation by electronic mail to:

Randall Snelling, Chief Physical Environment Officer
Randall.Snelling@dnvgl.com

After receipt of this written request, a contract amendment will be prepared and submitted to the hospital for approval.

DNV GL review of a hospital LSC waiver or FSES equivalency request will not begin until a signed contract amendment is received.

061915

Date CAP verified effective/closed:	***DNV GL reviewer:***
DNV GL final follow-up and closure of NC:	

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Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-5	**Physical Environment** Utility Management	☐ NC-1 Condition-level ☐ NC-1 ☑ NC-2	**PE.8(SR.2) / (SR.3) / (SR.6) / (SR.10)** *NFPA 110-2010;8.3.3,8.3.4,8.3.4.1,8.4.1,8.4.2, 8.4.2.3,8.4.3,8.4.4* *ISO 9001:2008;6.3*	485.623(c)

Requirement (Description):

PE.8 UTILITY MANAGEMENT

SR.2 The CAH shall have a process in place to evaluate critical operating components

SR.3 The CAH shall develop maintenance, testing, and inspection processes for critical utilities.

SR.6 The CAH shall provide for reliable emergency power sources with appropriate maintenance as required.

SR.10 All relevant utility systems shall be maintained inspected, and, tested.

Finding #1&2

NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition

8.3.3 *A written schedule for routine maintenance and operational testing of the EPSS shall be established.*

8.3.4 *A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available.*

8.3.4.1 *The permanent record shall include the following:*

(1) *The date of the maintenance report*
(2) *Identification of the servicing personnel*
(3) *Notation of any unsatisfactory condition and the corrective action taken, including parts replaced*
(4) *Testing of any repair for the time as recommended by the manufacturer*

8.4.1 *EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.*

8.4.2 Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:

(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer

(2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating

8.4.2.3 *Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.*

primary source.

8.4.3 *The EPS test shall be initiated by simulating a power outage using the test switch(es) on the ATSs or by opening a normal breaker. Opening a normal breaker shall not be required.*

8.4.4 *Load tests of generator sets shall include complete cold starts.*

ISO 9001:2008;6.3 Infrastructure

The organization shall determine, provide and maintain the infrastructure needed to achieve conformity to product requirements. Infrastructure includes, as applicable,
a) buildings, workspace and associated utilities,
b) process equipment (both hardware and software), and
c) supporting services (such as transport, communication or information systems).

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The requirement was NOT MET as evidenced by the following:

Finding #1
During the physical environment document review with hospital staff, the surveyor noted that the hospital was not conducting the required monthly Emergency Generator Test properly. The hospital is not running the emergency generator under full hospital load for the monthly load test.

Finding #2
During the physical environment document review with hospital staff, the surveyor noted there is no objective evidence the hospital is conducting an annual load bank test on the Emergency Generator. The Hospital's calculated full load for the emergency generator is less than 30% of the emergency generator's manufacturer's name plate full load. The Hospital is not checking or recording the emergency generator exhaust gas temperatures.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 LCH not running hospital generator on full load for the monthly load test as generator will not perform full load.
#2 Annual load bank test was not being performed at full load due to needing outside source to perform.

Organization Corrective Action Plan (CAP): #1 Weekly testing of the generator continues every Monday with full hospital load to be performed monthly as required.
#2 $1800 test to be performed by Cummins annually since full load is less than 30%. Emergency generator exhaust gas temperature are recorded every Monday on log.

Person/Function responsible for implementation of Corrective Action Plan:	Curt Langley, Plant Operations
Date for implementation of Corrective Action Plan: (generally within 60 days)	~~October 11, 2015~~ **UPDATE 9/22/2015 mns – September 27, 2015**
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Full hospital load to be included on weekly testing of the generator. $1800 full load test to be included in Safety Meeting bimonthly until completed, then added to annual testing.

DNV GL- HEALTHCARE USE ONLY

***CAP accepted date:* 09/15/2015**	***DNV GL reviewer:* R. Snelling**
Clarification requested date:	***DNV GL reviewer:***
Clarification request:	
Date CAP verified effective/closed:	***DNV GL reviewer:***
DNV GL final follow-up and closure of NC:	

DNV·GL

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
188730-2015-AHC-USA-NIAHO	8/1/2015	8/1/2018

This is to certify that:

Lauderdale Community Hospital

326 Asbury Ave, Ripley, TN 38063

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

March 1, 2016

Tammie Hardy
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: Certificate of Need Application -- CAH Acquisition Company 11, LLC d/b/a (Lauderdale Community Hospital) - CN1601-004
The construction and replacement of a 25 bed Critical Bed Access Hospital located at 326 Asbury Avenue, Ripley (Lauderdale County), TN 38063. The estimated project cost is $20,262,987.

Dear Ms. Hardy:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on March 1, 2016. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on May 25, 2016.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: March 1, 2016

RE: Certificate of Need Application
CAH Acquisition Company 11, LLC d/b/a (Lauderdale Community Hospital) - CN1601-004

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on March 1, 2016 and end on May 1, 2016.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Tammie Hardy

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the The Commercial Appeal (Name of Newspaper) which is a newspaper of general circulation in Lauderdale (County), Tennessee, on or before January 10 (Month / day), 2016 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

CAH Acquisition Company 11, LLC (Name of Applicant) Hospital (Facility Type-Existing)

owned by: HMC/CAH Consolidated, Inc. with an ownership type of LLC

and to be managed by: Rural Community Hospitals of America, LLC intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: See Attached Project Description

The anticipated date of filing the application is: January 15, 2016

The contact person for this project is Tammie Hardy (Contact Name) (Title)

who may be reached at: Lauderdale Community Hospital (Company Name) 326 Asbury Avenue (Address)

Ripley (City) TN (State) 38063 (Zip Code) 731 / 221-2200 (Area Code / Phone Number)

Tammie Hardy (Signature) 1-7-16 (Date) tammie.hardy@lauderdalehospital.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

CAH Acquisition Company 11, LLC Letter of Intent

Project Description:

CAH Acquisition Company 11, LLC, d/b/a Lauderdale Community Hospital, is located at 326 Asbury Avenue, Ripley, Tennessee and has a growing inpatient census averaging around 8.5 patients per day. Lauderdale Community Hospital is proposing to build a new 25 bed facility on its current campus consisting of 46,851 square feet at an expected construction cost (including site preparation work) of $19,999,460. The new hospital will replace the existing 33 year old facility that is outdated and does not provide the efficiencies that a new facility will provide. The new hospital will continue to offer the same services currently provided, which include acute, emergency, swingbed and outpatient services.

Supplemental #1
-Original-

CAH Acquisition Company 11, LLC

CN1601-004

SUPPLEMENTAL #1

January 29, 2016
9:59 am

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

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1. **Section A, Applicant Profile Item 2**

   Please provide an entire email address for contact and submit a replacement page. The LOI provides a contact number of 731-221-2200, but is listed as 731-220-2400 in the application. Please clarify.

   The contact number for Tammie Hardy at LCH is 731-221-2200; her email address is Tammie.Hardy@lauderdalehospital.com. The email address is very long therefore it has been included here

2. **Section A, Applicant Profile Item 3**

   Please clarify if CAH Acquisition Company 11, LLC currently or previously been under bankruptcy protection.

   CAH Acquisition Company 11, LLC filed for Chapter 11 reorganization on October 10, 2011 in the US. District Bankruptcy Court for the Western District of Missouri. On January 17, 2013, a Plan for Reorganization was approved by the bankruptcy court. The Final Decree was entered by the Court on March 29, 2013 and the case was closed. See Attachment 1

3. **Section A, Applicant Profile Item 5**

   Please provide the ownership structure of Rural Community Hospitals of America, LLC.

   RCHA is a West Virgina LLC. Its sole member is Sun Finance, Inc. which is also a West Virginia corporation. The shareholders of Sun Finance are Paul Nusbaum(50%) and Steve White(50%), both of which are West Virginia residents.

4. **Section B. I. Project Description and Applicant Profile Item 6**

   Please clarify the following from the above four bullet points: 1) Who will be holding the lease, 2) Who is paying for the construction of the hospital, 3) Please provide financial documentation the entity that will construct the hospital has the funds to do so, 4) If the applicant will lease the new hospital please specify in "Applicant Profile 6" on page 3 of the application, and provide a fully executed lease or an option to lease agreement.

   During the construction period, a NewCo will be established that will hold the lease. The NewCo will be partially owned and fully guaranteed by CBC Real Estate Group, LLC (CBC). CHHS will also be part of the NewCo as well as CFG. For funding capabilities with regard to CFG and CHHA, please refer to Attachment 2. The applicant will lease the new hospital. In Attachment 3, the latest term sheet regarding the lease is provided.

What is the relationship between HMC/CAH Consolidated, Inc. and Community Hospitality Healthcare Services (CHHS).

CHHS is a Community Development Entity which is required when utilizing New Market Tax Credits. Once the facility is built and the NewCo established, CHHS will become part of the NewCo.

Please provide an overview of CHHS.

CHHS is a nationally recognized community development entity specializing in investing in healthcare businesses and healthcare infrastructure in America's most severely distressed communities. CHHS provides catalytic debt and equity investments to high-impact projects in medically underserved low-income communities throughout the U.S. Investments are prioritized based upon their ability to provide healthcare services to low-income individuals and families, and provide entry-level jobs and upward mobility via career ladder resources. These investments have reduced the overall cost burden of care on a national basis while addressing disparities in low-income communities by providing increased access to care and employment opportunities. Project funding provides for expansion of services, construction and improvement of new or existing space, investments in job training, workforce development and career ladder programs as well as computer systems and medical equipment.

CBC Real Estate Group, LLC has a combined experience of over 100 years in commercial real estate development, brokerage, leasing, financing and property management. CBC principals combine to maintain real estate and financial holdings exceeding $400,000,000. During the last 30 years, CBC has been involved in the development and acquisition of more than 5 million square feet of commercial real estate projects throughout the country.

CFG is a leading provider of full-service, comprehensive financing solutions for healthcare facilities across the country.

5. **Section B. I. Project Description**

The applicant notes total project cost for the new facility will be approximately $23 million, of which $3 million (or approximately 23%) will be New Market Tax Credits on pages 6 and 23. However, there appears to be a calculation error in the percentage calculation. Please clarify.

The anticipated percentage is actually 15%. CHHS anticipates that the tax credits could cover as much as 23%, but the applicant used a more conservative 15%.

In addition, the Project Costs Chart totals $20,044,459, not $23,000,000 as reflected in the Project Summary on page 6. Please clarify.

The total project comes out to $23,000,000 because there is $3,000,000 of debt refinancing included in the project. However, because the refinancing is not related in any way to the construction, it was excluded from the "Projects Costs Chart." For purposes of this application the total project cost is $20,126,780.

Please provide an overview of New Market Tax Credits (NMTC) and how it applies to this project.

The New Markets Tax Credit Program (NMTC) was designed by Congress to attract private-sector capital investment into the nation's low-income areas to help stimulate economic growth and create jobs by financing community development projects and business expansion.

This program was established by Congress in December 2000 as a credit against federal income taxes for making qualified equity investments in investment vehicles known as Community Development Entities (CDEs). The credit provided to the investor (either corporate or individual) totals 39 percent of the cost of the investment and is claimed over a seven-year period. The CDE's are charged with making investments into qualified projects or businesses in low-income communities.

The program is overseen by the Community Development Finance Institutions Fund, an arm of the US Treasury Department. It is run on a competitive basis, providing the authority to allocate the resource to projects and businesses to the specialized entities noted above- Community Development Entities. Rules regarding the types of businesses that can be funded and the types of funding that can be provided are extensive and it is a function of the CDE's receiving the allocations to make sure that the projects receiving allocations are compliant with the program. Specific exclusions include land-banking, golf courses, massage parlors and tanning salons as well as farms and liquor stores. The resource is often used to help finance the gap on commercial real estate projects and to fund business expansion. Each CDE that receives an allocation has specific guidelines that it must meet in order to remain in compliance with its agreement to use the resource. It is important to find out from the CDE that you may be working with if your project is eligible for their resources early on.

Many projects blend other sources of subsidy with the New Markets Tax Credit. Historic Credit, both federal and state, Brownfield grants and notes and tax-incremental financing are common additional resources that are used to help make transactions more financially viable. One important thing to remember when you are considering a NMTC subsidized project, however, is that this resource is only able to fill a financial gap; it will not make an infeasible project feasible.

New Markets Tax Credit represents $3,000,000 or 15 % of the funding for this project.

It is noted the service area consists of zip code 38603 located in Ripley County, Tennessee. However, it appears a portion of Zip Code 38603 is located in the State of Missouri. Please clarify. If so, is there a bridge or ferry for Missouri residents in Zip Code 38603 to have access to Lauderdale Community Hospital?

The zip code for Ripley, TN is actually 38063, as is indicated in the application. Zip code 38063 is wholly in Lauderdale County and the State of Tennessee.

Please clarify the reason the applicant chose a Zip code 38603 as a service area, rather than Lauderdale County as a whole.

Zip code 38063 was characterized as the PRIMARY service area because 78% of the hospital's business comes from that zip code.

Please clarify if the existing hospital has a cafeteria, and if the future hospital will have a cafeteria. Please discuss.

The existing hospital does have a cafeteria. The future hospital will also have a cafeteria. In the "Square Footage and Cost per Square Footage Chart", the cafeteria and kitchen combine for a total of 2,733 sq. ft.

Please provide a brief overview of the MRI and CT scanner services Lauderdale Community Hospital provides.

MRI services are provided via a mobile unit that is licensed for four days a week but is currently available one day a week. CT scanner services is available 24/7 as the scanner is inhouse.

6. **Section B. II. A.**

The applicant notes the expected construction cost (including site preparation work) is $19,999,460. However, that is the estimated project cost minus the CON filing fee. Please clarify.

The construction cost with site work is actually $15,313,361

Table 1: Project Cost

Project Cost Chart Chart Description	Chart Location	Construction Cost
Preparation of Site	Project Cost Chart, A.4	1,290,053
Construction Costs	Project Cost Chart, A.5	14,023,308
Construction Cost with Site Work		15,313,361
Architectural Fees	Project Cost Chart, A.1	1,145,147
Contingency Fund	Project Cost Chart, A.6	1,190,952
Interest Incurred during Construction period	Project Cost Chart, C.3	2,350,000
Project Cost less CON Filing Fee		19,999,460

The square footage and cost per square footage chart is noted. However, please revise the chart to include the Proposed Final Cost/SF section and resubmit.

See Attachment 4

Please indicate the existing average patient room size and the proposed patient room size of the 25 bed newly constructed hospital.

Room size in the current facility is based on whether they are private or semiprivate rooms. Private rooms have a total of 251 sq feet while a semiprivate is 282.6 Sq Ft. In the replacement facility, private rooms will total 237 sq ft.

Please clarify if all patient rooms will be private or semi-private.

Yes, all patient rooms will be private.

7. **Section B. II. D.**

Please clarify if the current 25 bed hospital has ever been renovated. If so, please discuss.

LCH was acquired in March of 2010 and since that date there have been no major renovation which is also the impetus for the proposed project. Since acquisition of the hospital it has always been the intent to replace the outdated facility.

8. **Section B. III. A. Plot Plan**

   The plot plan is noted. Please provide an enlarged plot plan of lot 2 for the replacement hospital.

   See Attachment 5

9. **Section B. IV. Floor Plan**

   The floor plan is noted. However, please provide larger more legible unduplicated copies of each wing and section on 8 ½ x 11 paper.

   See Attachment 6

10. **Section C. (Need) 1. Specific Criteria (Construction, Renovation, Expansion, and Replacement of Healthcare Institutions) 1.b**

    Please clarify the reason acute bed discharges decreased from 356 in 2013 to 255 in 2015, while swing bed utilization increased from 72 to 117 during the same timeframe.

    During that timeframe, while inpatient acute discharges were decreasing, observation days were increasing. The applicant believes that this is part of a trend towards more outpatient services than inpatient. Swing bed utilization increased in response to efforts to bring local patients back to LCH for their rehabilitation instead of being discharged early from larger, PPS hospitals.

    Why did inpatient lab and physical therapy inpatient services increase from 2013 to 2015 while inpatient acute and swing bed discharges decreased.

    Inpatient ancillary services began increasing independently of discharges in 2014 when LCH hired a hospitalist to assist with weekend and overnight care, relieving the burden from local providers. In addition, while it is true that inpatient acute discharges did decrease from 2013 to 2015, swing bed discharges actually increased from 72 to 117 in that time period. It is this increase that also explains the increase in lab and physical therapy inpatient services; swing bed patients tend to make more use of ancillary services than acute especially therapy.

    What factors attributed to the decrease in surgeries from 296 in 2013 to 56 in 2015?

    The only surgeon on staff gradually reduced his workload and retired in 2015. The Applicant is currently in the final stages of recruiting a general surgeon. He is reviewing the Letter of Intent and coming back on February 1st.

    The applicant is also pursuing the opportunity of partnering with a group in Jackson, TN. They have a variety of specialists who provide pediatric, adolescent, and adult medical and

surgical services. The applicant is looking to partner with this well-established group and offer the same services to our community.

While historically, the applicant has employed a surgeon, one is not employed as of the submission of this document. As a result, no revenue, salaries or direct expenses are included in projected financials on the Projected Data Chart.

What factors attributed to the decrease in overall outpatient services from 2013 to 2015?

There are three factors that impact this change. First, a new urgent care clinic opened in Riply, TN in July 2014, which performs lab and x-ray services. Second, a new rural clinic opened in Ripley, TN in February, 2013. Last, with some outpatient procedures considered elective, higher deductibles become a factor in the decision of having any outpatient services performed.

How much of the overall lower utilization in hospital services from 2013 to 2015 can be attributed to the condition of the physical plant and equipment?

With an older, outdated building, the recruitment of a surgeon and family practitioner has been more difficult. The ability to both recruit and retain highly qualified professionals to staff the clinical and ancillary departments is certainly a challenge.

11. Section C. (Need) 3. Service Area County Level Map

The County level map designating the applicant's declared service area is noted. However, please label Tennessee Counties and submit.

See Attachment 7

12. Section C, Need, Item 4.A.

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for your proposed service area.

Variable	Lauderdale County (for comparison Purposes)	Zip Code 38063**	Tennessee
Current Year (2015, Age 65+*	3,982	2,572	1,051,862
Projected Year (2019), Age 65+*	4,452	2,905	1,219,696
Age 65+, % Change*	11.8%	12.9%	16%
Age 65+, % Total (2015)*	14.0%	14.7%	15.6%
2015, Total Population*	28,529	17,481	6,735,706
2019, Total Population*	29,055	17,647	7,035,572
Total Pop. % Change*	1.8%	1.0%	4.5%
TennCare Enrollees*	8,093	4,959	1,481,270
TennCare Enrollees as a % of Total Population*	28.4%	28.4%	22.0%
Median Age 2015**	37.1	37.0	38.7
Median Household Income 2015**	$32,533	$31,064	$44,301
Population % Below Poverty Level***	26.00%	34.10%	17.6%

* State of Tennessee

**Tactician / Mapscape.com

*** http://quickfacts.census.gov/qfd/states/47/4763340.html

What is the source of their ZIP Code demographics provided in the application?

The applicant uses Tactician.com for demographic information.

13. Section C. (Economic Feasibility) Item 1. (Project Cost Chart)

The following definition regarding items acquired by lease in Tennessee Health Services and Development Agency Rule 0720-2-.01 (12)(d) states " If the acquisition is by lease, the cost is either the fair market value of the property, or the total amount of the lease payments, whichever is greater."

Please find attached the appraisal of building and land for LCH (Attachment 8). The appraisal of land was $120,000 for all 34.95 acres. Per the plot plan, parcel 2, where the new facility will be built, is marked at 23.976 acres. Based on acreage, the land of parcel 2 should be valued at $82,321 ($120,000 / 34.95 * 23.976= $82,321). This amount has been added to the Project Cost Chart. See Attachment 9

Please provide documentation of the fair market values of both the land and the building and the calculation of the total amount of the lease payments over the term of the lease. Please insert the greater amount in line B.1 of the Project Costs cost and resubmit a replacement page.

See Attachment 9

Please provide documentation from a licensed architect or construction professional:

1) **a general description of the project,**
2) **his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and**

3) **attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the latest AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.**

In Attachment 10, a letter, which includes, a brief project description and documentation on construction has been provided by the contractor JeDunn. JeDunn is a privately owned construction company that was founded in 1924 and has grown to be #186 on Forbes list of largest private companies.

A letter of attestation has also been provided in Attachment 10 from the architect on the project.

14. Section C. (Economic Feasibility) Item 2. Funding

The documentation of the availability of funding is noted. However, please revise the letters to reference the dollar amount of funding that will be provided.

See Attachment 11

The funding of 75% of project costs from CFG Capital Markets, LLC and 23% of the capital costs from Community Hospitality Healthcare Services is noted. However, how will the remaining 3% of Project Costs be funded?

The percentages are actually 85% ($17M/$20M) from CFG Capital Markets, LLC and 15% ($3M/$20M) from Community Hospitality Healthcare Services.

The applicant notes total Project Costs of $23,000,000 which does not match the Project Costs Chart. If needed, please provide a replacement page for page 23 reflecting the correct funding amount.

As discussed in question 5 above, the applicant has included in the project $3,000,000 of debt refinancing which is not related in any way to the construction. Because of this, it was excluded from the "Projects Costs Chart." The project cost is $20,126,780.

15. **Section C. (Economic Feasibility) Item 3**

Please provide factors that contribute to higher construction costs of $299.32 for the proposed hospital project which is slightly higher than the $296.52 cost PSF 3rd quartile of hospital projects approved from 2012-2014.

JeDunn Construction estimates that construction inflation was 3% in 2015. The historical inflation adjusted cost per square foot for the 3rd quartile for 2016 is $305 per square foot.

16. **Section C. (Economic Feasibility) Item 4**

The applicant completed older versions of the Projected and Historical Data Chart. Please complete the attached Historical and Projected Data Charts and submit. Please specify the unit of measure (i.e. - patient days) in line "A. utilization Data" for both of the above charts.

See Attachment 12

Historical Data Chart

There appears to be calculation errors in total operating expenses for 2013 and 2014. Please correct and submit a revised Historical Data Chart.

See Attachment 12

Why did charity care decline from $837,130 in 2013 to $274,237 in 2015?

A new urgent care center and a rural clinic opened in Ripley, TN over the last couple of years. They have taken cases away where charity care would be an option.

The retirement of principal in the amount of $1,002,827 is noted for 2015. However, please explain how the Capital Expenditure affected Net Operating Income Less Capital Expenditures. Does this mean there in no remaining debt for the existing facility?

The retirement of capital in the amount of $1,002,827 is not a true impact on profitability in 2015. The $1,002,827 was only the principal payments made on debt in 2015 while the capital interest was the interest payments made in 2015. Capital interest expense is an expense on our income statement but retirement of capital is not an expense line on our financial statements. Depreciation expense is the retirement of capital expense over the useful life of the debt instrument. The reporting of retirement of capital "doubles up" our retirement of capital. When we finance the purchase of capital expenditures, we try to set up our debt instrument loans to the same length of time as the useful life of the capital expenditures. That way over the useful life of the capital the depreciation expense

matches our retirement of capital. Since the depreciation is straight line, an equal amount is depreciated each 12 months. When financing a debt instrument, less is paid in the first 12 months of the retirement of capital than the last 12 months of retiring the debt instrument.

Projected Data Chart

Please clarify why there are no management fees in the Projected Data Chart.

There are management fees in the projected data chart; they are included in line 8. However, with the new form provided, management fees will be much easier to discern.

See Attachment 12

Why is there no dollar amount in B.4 "other operating revenue" in the Projected Data Chart in Year One and Two, while there was $500,784 assigned in the Historical Data Chart in 2015?

Other operating revenue is included in line B-4 on the historical data chart and on line E on the projected data chart. This will be corrected on the new, provided forms.

See Attachment 12

Is it realistic for outpatient services to increase from $14,753,755 in 2015 to $34,395,985 in Year One (2018) and for emergency services to decrease from $20,930,088 in 2015 to $8,572,030 in Year One? Please discuss.

The allocation of revenue was not consistently projected into the categories. This has been corrected on the new forms. See attachment 12

Is it noted the applicant is a for profit hospital. Please clarify the reason there are no taxes allocated in Year One and Year Two in the Projected Data Chart?

The Hospital is a part of a consolidated tax return which had no taxable income in 2014. In addition, the consolidated tax return for HMC/CAH continues to have Net Operating Loss carryforwards that would offset future income tax.

17. Section C. (Economic Feasibility) Item 5

Table sixteen identifying the project's average gross charge, average deduction from operating revenue, and average net charge is noted. The amounts do not match up with the Projected Data Chart. Please clarify and resubmit if needed.

The applicant pulled up gross charges, deductions, and net patient revenue from the projected data chart and they do match the figures in "Table Nine." Please keep in mind that for purposes of gross revenue, other operating revenue was excluded in "Table Nine" because it is not 'patient revenue'.

18. Section C. (Economic Feasibility) 7.

Please indicate the amount of utility cost savings the applicant will experience in Year One (2018) by moving to a new replacement hospital.

It is estimated that the new facility will incur approximately $258,000 in utility cost in 2018. The applicant expects that to increase to approximately $266,000 by 2019. That is an annual cost savings of approximately $174,000 from 2015 to 2018. While some of these savings can be attributed to a new, energy efficient facility, it is also because the applicant will have emigrated from a facility of 78,341 Sq Ft to 46,851 Sq Ft.

19. Section C. (Economic Feasibility) Item 9.

The applicant notes the hospital provides over $4 million in indigent care annually. Please clarify if the $4 million dollar amount includes Provision for Bad Debt.

Yes, that figure includes provision for bad debts. Please see below the calculation of uncompensated care for LCH.

Table 2

Type	FY 2012	FY 2013	FY 2014
Charity	$529,165	$837,130	$176,674
Bad Debt	$3,972,229	$3,415,875	$3,835,255
Medicaid Uncompensated	-	$360,498	$174,521
Medicare Sequestration	-	$56,359	$43,455
Total Uncomp Care	$4,501,394	$4,669,862	$4,229,905

20. Section C. (Economic Feasibility) Item 10.

Please provide the most recent audited financial statements for Lauderdale Community Hospital.

Lauderdale Community Hospital does not get audited as an individual business. The audit is done of the parent company, HMC/CAH Consolidated Inc, of which Lauderdale is a member. The latest audit for HMC/CAH Consolidated Inc. was provided with the original application as attachment 13.

The consolidated balance sheet for HMC/CAH, Inc. for the period ending September 30, 2014 indicates total liabilities of $27,826,892 exceed current assets of $18,814,047. Please clarify.

The primary reason for a low liquidity ratio is related to HMC/CAH's exit from bankruptcy. At the time, HMC/CAH was burdened with several million dollars of debt and millions in extraordinary expense items. We are recovering from our exit from bankruptcy; as our financials indicate. However, even with our low current ratio, it has not discouraged lenders from working with HMC/CAH to finance replacement facilities. It is not our current financial condition but the financial advantages the applicant would have with a new facility that is driving lender interest.

21. Section C. (Economic Feasibility) Item 11.b

If approved, please discuss what will happen to the existing hospital.

As noted in the application, the disposition of the existing building is in flux. There is talk of donating it to the County to be used for Medical Professional Education. But there is

also the option of selling it to be used as a nursing home. The disposition of the facility will probably not be known until the latter months of the construction period.

22. Section C. Orderly Development, Item 7.d

Please indicate the date of the last survey by the Tennessee Department of Health. If needed, please provide a copy of survey and acceptance of the corrective action plan, if applicable.

The date of the last survey was June 15, 2011. See Attachment 13

23. Section C. Orderly Development, Items 8 and 9

Please provide a response indicating if there are any final order or judgements by a licensing agency, or any final civil or criminal judgments for fraud or theft against any person or entity with more than 5% ownership interest in the project.

As of today's date, the applicant is not aware of any orders or judgments against any person or entity with more than 5% ownership interest in the project.

SUPPLEMENTAL #1
January 29, 2016
9:59 am

AFFIDAVIT

STATE OF MISSOURI

COUNTY OF JACKSON

NAME OF FACILITY: LAUDERDALE COMMUNITY HOSPITAL

I, Trent Skaggs, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Trent Skaggs Exec VP
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28th day of January, 2016, witness my hand at office in the County of Jackson, State of Missouri

Linda K. Way
Notary Public - Notary Seal
STATE OF MISSOURI
Jackson County
My Commission Expires: Nov. 17, 2018
Commission #14444354

Linda K. Way
NOTARY PUBLIC

My commission expires Nov 17, 2018

HF-0043

Revised 7/02

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 1

Question 2- Section A, Item 3

Bankruptcy Decree

Attachment 1
Question 2- Section A, Item 3
Bankruptcy Decree

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE WESTERN DISTRICT OF MISSOURI
KANSAS CITY DIVISION

In re:	)	Case No. 11-44748-11
	)	
CAH ACQUISITION COMPANY 11, LLC	)	Chapter 11
	)	
(EIN: 27-0560527)	)	
Reorganized Debtor.	)	
	)	

ORDER GRANTING MOTION OF THE REORGANIZED DEBTORS FOR ENTRY OF A FINAL DECREE CLOSING CERTAIN CHAPTER 11 CASES – FINAL DECREE AND ORDER CLOSING CASE

This matter having come before the Court upon the motion (the "Motion")[1], dated February 27, 2013, of the above-captioned reorganized debtor and its affiliated debtors (collectively, the "Debtors"), for entry of request entry of a final decree closing the Completed Cases, [Docket No. 994]; and the Court having reviewed the Motion; and having determined that the relief requested is in the best interests of the Debtors, their estates, their creditors and other parties-in-interest; and having considered the statements of counsel and the evidence adduced with respect to the Motion at a hearing before the Court; and the Court having found that (i) the Court has jurisdiction over this matter pursuant to 28 U.S.C. §§ 157 and 1334, (ii) venue for this matter is proper in this district pursuant to 28 U.S.C. §§ 1408 and 1409, (iii) this is a core proceeding pursuant to 28 U.S.C. § 157(b), (iv) the estate of the above-captioned Debtor has been fully administered, and (v) the Joint Plan has been substantially consummated; and it appearing that notice of the Motion and opportunity for a hearing with respect thereto were good and sufficient under the particular circumstances and that no other or further notice need be given; and upon the record herein; and all objections to the Motion having been overruled, withdrawn, or

[1] Unless otherwise defined herein, capitalized terms used herein shall have the meanings ascribed to them in the Motion.

otherwise resolved; and after due deliberation thereon; and good and sufficient cause appearing therefor, it is hereby

ORDERED, ADJUDGED AND DECREED THAT:

1. The Motion is GRANTED with respect to the above-captioned Debtor and, accordingly, the Chapter 11 case of the above-captioned Debtor shall be closed effective as of March 29, 2013.

2. The Debtor shall pay any remaining U.S. Trustee Fees owed for any time period from January 1, 2013 through the date of the entry of this Order and Final Decree pursuant to 28 U.S.C. § 1930(a)(6) after the entry of this Order and Final Decree and the Debtor has filed the appropriate quarterly report. Quarterly fees for all previous periods have been paid in full.

3. The Court shall also retain jurisdiction to enforce the terms of this Order which shall be effective as of March 29, 2013.

Dated: March 29, 2013
Kansas City, Missouri

/s/Dennis R. Dow
Hon. Dennis R. Dow
United States Bankruptcy Judge

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 2

Question 4, Section B, Item I

Financial Capability Statement

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Attachment 2
Question 4, Section B, Item I
Financial capability

CBC REAL ESTATE GROUP
FINANCIAL CAPABILITY STATEMENT

Background

CBC Real Estate Group has a combined experience of over 100 years in commercial real estate development, brokerage, leasing, financing and property management. With our extensive experience with build-to-suit development work with many healthcare groups plus federal and state agencies, we have been required to demonstrate our ability to design projects that meet unique requirements set forth by the users of the buildings. The vast majority of our past experience and current focus has been with the public/private partnership niche. We have proven expertise managing through unique financing requirements and have the experience and relationships to structure atypical lease arrangements when necessary.

CBC Real Estate Group is typically a long-term owner of projects that it develops. It should be noted that primary principals of CBC Real Group have real estate and other holdings in properties with aggregate value of approximately $400 million. With projects where we maintain an ownership position, we prefer to perform the ongoing property management, utilizing the expertise of our sister company, USFP Property Management Inc. USFP Property Management currently manages 2.1 million square feet of property. That number is divided into 25 government properties (primarily federal), comprised of approximately 1.3 million square feet in 15 states, and 39 other retail, medical and industrial commercial properties.

During the past 30 years, the principals of CBC Real Estate Group have been involved with the development and acquisition of more than 5 million square feet of commercial real estate projects throughout the country. In addition, our management team has leveraged its collective relationships within the capital markets to finance over $3 billion of debt and equity.

Potential Sources of Debt, Equity and/or Public Participation

With our proven to ability to raise equity capital, we have an extensive background working with various debt providers for projects. Given our history of developing and acquiring hundreds of millions of dollars in commercial real estate, we are always attuned to the debt capital markets and the various sources including commercial banks, life insurance companies and the CMBS debt capital markets. We can provide specific evidence and examples of our ability to finance projects upon request.

The following is a list of financial institutions and advisor that we have recently worked with:

- Wells Fargo
- BMO Harris
- Bank of America
- Zions National Bank
- PNC Bank
- Fifth Third Bank
- The Private Bank

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Sample of Recent Track Record (does not include all of CBC's projects)

Property	Location	Total SF	Financing	Debt Structure	Completion Year	Est Project Cost	Debt
Shoal Creek Village-Retail	Kansas City, MO	62,189	Crossfirst Bank	80/20%	2014	$10,603,000	(8,339,000)
Marshalltown Surgical Center	Marshalltown, Iowa	73,041	Union Bank	80/20%	2015	$28,058,000	(22,086,000)
Tallahassee VA	Tallahassee, FL	184,725	Fifth Third Bank	90 /10%	2016	$74,884,000	(65,617,000)
Grand Rapids VA	Grand Rapids, MI	119,524	The Private Bank	90 /10%	2014	$36,575,000	(32,900,000)
Colorado Springs VA	Colorado Springs, CO	89,336	The Private Bank	90 /10%	2014	$31,475,000	(28,330,000)
Shoal Creek Village-Land Dev	Kansas City, MO		Crossfirst Bank	75 /25%	2014	$6,644,000	(5,883,000)
Muskogee DOJ	Muskogee, OK	33,119	Zions Bank	90 /10%	2013	$13,440,000	(10,620,000)
Laredo VA	Laredo, TX	22,350	Citizens Bank	90 /10%	2013	$9,460,000	(8,514,000)
Jacksonville VA	Jacksonville, FL	130,049	Wells Fargo	90 /10%	2012	$58,996,000	(35,442,000)
DHS Salt Lake	Salt Lake City, UT	69,225	Zions Bank	90 /10%	2011	$25,500,000	(16,900,000)
Jacksonville FBI	Jacksonville, FL	129,895	M&I Bank	100%	2009	$44,724,000	(44,891,000)
US Federal Courthouse	Great Falls, MT	48,411	M&I Bank	100%	2009	$18,905,000	(18,339,200)
DHS Denver	Denver, CO	54,927	Bank of America	90 /10%	2009	$14,441,000	(13,554,200)
Kansas Dept. of Social Rehab	Kansas City, KS	72,900	M&I Bank	90 /10%	2008	$14,580,000	(11,891,000)
Birmingham DEA	Birmingham, AL	38,445	M&I Bank	100%	2007	$11,743,000	(11,743,000)
OSHA Science & Tech Center	Salt Lake City, UT	75,000	Bonds - Piper Jaffrey	100%	2005	$21,865,000	(21,865,000)
Austin SSA	Austin, TX	23,311	Enterprise Bank	100%	2005	$4,309,000	(4,309,000)
Birmingham FBI	Birmingham, AL	145,360	Colonial Bank	100%	2005	$17,766,000	(17,766,000)
Liberty Triangle Retail	Liberty, MO	350,000	Bonds/ Bank Debt/CID & TIF	100%	2004	$35,000,000	(35,000,000)
Kansas EPA	Kansas City, KS	71,979	Bonds - Piper Jaffrey	100%	2002	$22,722,000	(22,075,000)
		1,793,786				**$501,690,000**	**(436,064,400)**

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 3

Question 4- Section B, Item I

Lease Term Sheet

Attachment 3
Question 4, Section B, Item I
Lease Term Sheet

Lessor Name

LEASE TERM SHEET

This term sheet is not intended to be a binding agreement or to give rise to any legal liability between the parties, but is merely an expression of their intent with respect to the Transaction, defined below, under discussion and sets forth preliminary negotiating points. For purposes of this agreement, the Transaction is defined as the development of an approximately $23,000,000 replacement critical access hospital in Ripley, Tennessee. The agreement of the parties will only become binding upon the execution of definitive agreements with respect thereto.

Lessee:	CAH of Lauderdale, LLC or affiliate ("Lessee")
Lessor:	An entity to be formed and managed by [Principals of the Lessor], principals of [Lessor Name]. ("Lessor")
Leased Property:	The Lessee will lease from the Lessor the land and improvements located at 326 Ashbury Avenue, Ripley, Tennessee 38063 consisting of 23.976 acres of land and a to-be-constructed 25-bed replacement critical access hospital of approximately 44,000 square feet and a 12,000 square foot Clinical Building (the "Property"). Lessee accepts the Property in "AS IS" condition. Lessee shall work with the project Developer to ensure satisfaction with the plans, specifications, scope of work and schedule for the Building to ensure adequacy and acceptability thereof. Lessee shall provide its own supplies, FFE and other items not included in Developer's scope of work. Lessor is not making any warranties or representations concerning the Property or its suitability for its intended use.
Lease Type:	The Lease shall be absolute net in nature whereby the Lessee shall be responsible throughout the term of the Lease for the payment of all amounts, liabilities, obligations and impositions related to the ownership, use, possession and operation of the leased Property, including, but not limited to, all utilities, all real estate taxes, insurance premiums, maintenance, repairs and capital improvements. This responsibility of the Lessee will be in addition to the payment of Base Rent described below.
Lease Term:	The Lease shall be for a term of twenty (20) years. Lessee shall have two, 5-year renewal options.
Base Rent:	The annual Base Rent for the first 12-month period following the issuance of a Certificate of Occupancy (the "CO") shall be an amount equal to 10.5% of the Transaction less an adjustment for New Market Tax Credits (the "NMTC Adjustment"). The NMTC Adjustment is expected to equal to no less than $300,000 or 10%

	of the value received from the New Market Tax Credits currently contemplated. For avoidance of doubt, is it proposed the annual Base Rent for the first 12-month period following CO shall be $2,115,000 and shall be paid monthly in 12 equal amounts each year on the first (1st) day of each Lease month.
Facility Renovations:	Lessee shall have the right to modify the Property as necessary subject to Lessor's approval of plans and the contractor which approval shall not be unreasonably withheld. Lessee shall obtain a payment and performance bond to ensure lien free completion of such alterations.
Adjustment of Rent:	Commencing on the date that is one year after lease commencement and each year thereafter, the annual Base Rent shall be increased by one and a half percent (1.5%). The Annual Rent for the first year of the first renewal option shall be the greater of: a) market rent, or b) 101.5% of the prior year's rent. In either case, the Annual Rent shall be subject to annual increases of 1.5% thereafter.
Use of Leased Property:	Lessee covenants that it will obtain and maintain throughout the lease term all approvals needed to use and operate the Property as a critical access hospital. Lessee covenants that during the lease term it will continuously operate the Property only as a provider of healthcare services and shall maintain its certifications for reimbursement and licensure and all necessary accreditations.
Insurance Requirements:	Lessee shall carry all forms of insurance coverage (e.g. GL/PL, Property, Earthquake, Flood, Wind, Business Interruption, Employee Dishonest/Theft, Auto, etc.) acceptable to Lessor's lender and loan Servicer including but not limited to coverage amounts and Insurer rating. Lessor and Lessor's lender shall be named as an additional insured party on all Lessee policies.
Financial Statements:	Lessee shall provide monthly financials and audited annual financial statements to Lessor in a timely manner throughout the lease term.
Lessee Repurchase Option:	So long as Lessee is not in default on this Lease, Lessee shall have the option, commencing on the date that is a minimum of 120 months after the closing of the Transaction and expiring at the end of 144 months following the closing of the Transaction, to repurchase the Property at a pre-established pricing methodology. The repurchase price shall be equal to the sum of the contractual rent payments to be received by Lessor for the immediate 12-month period after the repurchase date plus the annual NMTC Adjustment, divided by ten percent (10.0%). This purchase option is non-transferable.

Assignment and Subletting:	Lessee shall not assign the Lease or sublease any space in the Property without the prior written consent of lessor.
Capital Improvement Obligation:	Lessee shall be required to make capital improvements and repairs to the Property and the physical plant of the Property in an amount equal to the minimum required by any lender in connection with consummating Lessor's financing or re-financing. Proof of such expenditures shall be provided at the end of each Lease year or upon request. Lessee shall timely complete at its own expense all repairs and replacements required by any lender in connection with consummating Lessor's financing or re-financing.
Events of Default:	Events of default by Lessee shall include all standard and customary events, including, but not limited to, failure to pay Base Rent, failure to pay real estate taxes, bankruptcy filing, loss of necessary licensing, abandonment, etc.
Events of Performance Default:	Coverage covenants (To be discussed)
Credit Enhancement:	The CAH Management Company or affiliate will provide a corporate guaranty for lease payments of the facility. Subject to Lessor's review of the corporate financials, additional guarantor(s) may be required. Lessor will also receive a security interest in all Lessee's assets and personal property at the facility. In addition, Lessee shall be required to fund an amount equal to six month's Base Rent as security deposit paid into the account in 48 equal monthly payments beginning at the start of the Lease. The security deposit shall be increased every three years based on the then current Base Rent.
Covenants:	Standard and customary financial covenants to secure refinancing. (To be discussed)
Cooperation & Compliance With Lessor Financing:	Lessee, shall execute such documentation as is typically required by Lessor's lender (government agency or a private lender), including but not limited to a Lessee Regulatory Agreement, Deposit Control Agreements, SNDAs, Estoppel certificates, Subordination of Management Agreement, and Intercreditor Agreements with Lessee's Accounts Receivable Lender. Lessee shall be responsible for all expenses in connection with its own review of the aforesaid documentation.

In addition, to the terms laid out above, the Lease shall include all standard and customary language and agreements regarding casualty and loss, condemnation, insurance proceeds, Lessee's personal property, indemnification, quiet enjoyment, etc.

Lessor:

[Lessor Name]

By: _____

Lessee:

CAH of Lauderdale, LLC

By: _____

Larry Arthur
Managing Member

Parent:

HMC/CAH Consolidated

By: James W. Shaffer

Jim Shaffer
President

57

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 4

Question 6- Section B, Item II(A)

Revised Square Footage and Cost per Square Foot Chart

SUPPLEMENTAL #1

January 29, 2016
9:59 am

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
A & G	Hospital	6893	N/A	New Facility	N/A	3044	3044	N/A	299.32	299.32
Housekeeping	Hospital	1428	N/A	New Facility	N/A	122	122	N/A	299.32	299.32
Dietary	Hospital	3356	N/A	New Facility	N/A	1676	1676	N/A	299.32	299.32
Cafeteria	Hospital	1885	N/A	New Facility	N/A	1057	1057	N/A	299.32	299.32
Central Svcs/Supply	Hospital	2538	N/A	New Facility	N/A	2396	2396	N/A	299.32	299.32
Medical Records	Hospital	1791	N/A	New Facility	N/A	753	753	N/A	299.32	299.32
Emp Benefits Department	Hospital	157	N/A	New Facility	N/A	104	104	N/A	299.32	299.32
Nurse Adm	Hospital	799	N/A	New Facility	N/A	230	230	N/A	299.32	299.32
Pharmacy	Hospital	1165	N/A	New Facility	N/A	587	587	N/A	299.32	299.32
Adults & Peds	Hospital	21142	N/A	New Facility	N/A	9784	9784	N/A	299.32	299.32
Operating Room	Hospital	8233	N/A	New Facility	N/A	4877	4877	N/A	299.32	299.32
Radiology Diag	Hospital	4965	N/A	New Facility	N/A	2536	2536	N/A	299.32	299.32
CT Scan	Hospital	400	N/A	New Facility	N/A	616	616	N/A	299.32	299.32
Laboratory	Hospital	2186	N/A	New Facility	N/A	2120	2120	N/A	299.32	299.32
Respiratory Therapy	Hospital	1831	N/A	New Facility	N/A	437	437	N/A	299.32	299.32
Physical Therapy	Hospital	5131	N/A	New Facility	N/A	0	0		0	0
Occupational Therapy	Hospital	864	N/A	New Facility	N/A	0	0		0	0
Emergency	Hospital	5012	N/A	New Facility	N/A	2910	2910	N/A	299.32	299.32
Other	Hospital	3610	N/A	New Facility	N/A	6939	6939	N/A	299.32	299.32
B. Unit/Depart. GSF Sub-Total		73406				40190	40190	N/A	299.32	299.32
C. Mechanical/ Electrical GSF		4935				1660	1660	N/A	299.32	299.32
D. Circulation /Structure GSF		N/A				5001	5001	N/A	299.32	299.32
E. Total GSF		78341				46851	46851	N/A	299.32	299.32

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 5

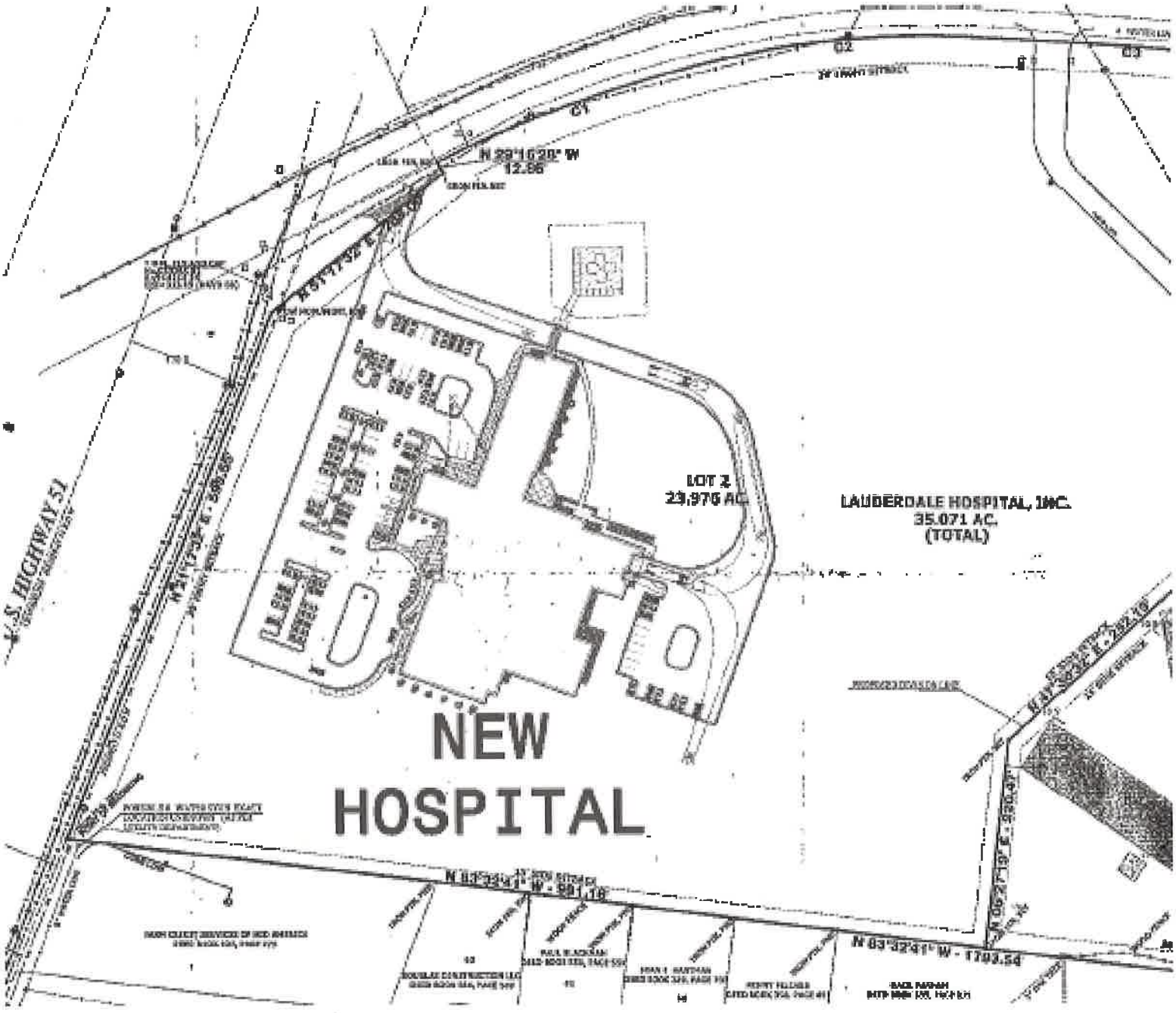
Question 8- Section B, Item III(A)

Plot Plan

SUPPLEMENTAL #1

January 29, 2016
9:59 am

Attachment 5
Question 8- Section B, Item III (A)
Plot Plan



SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

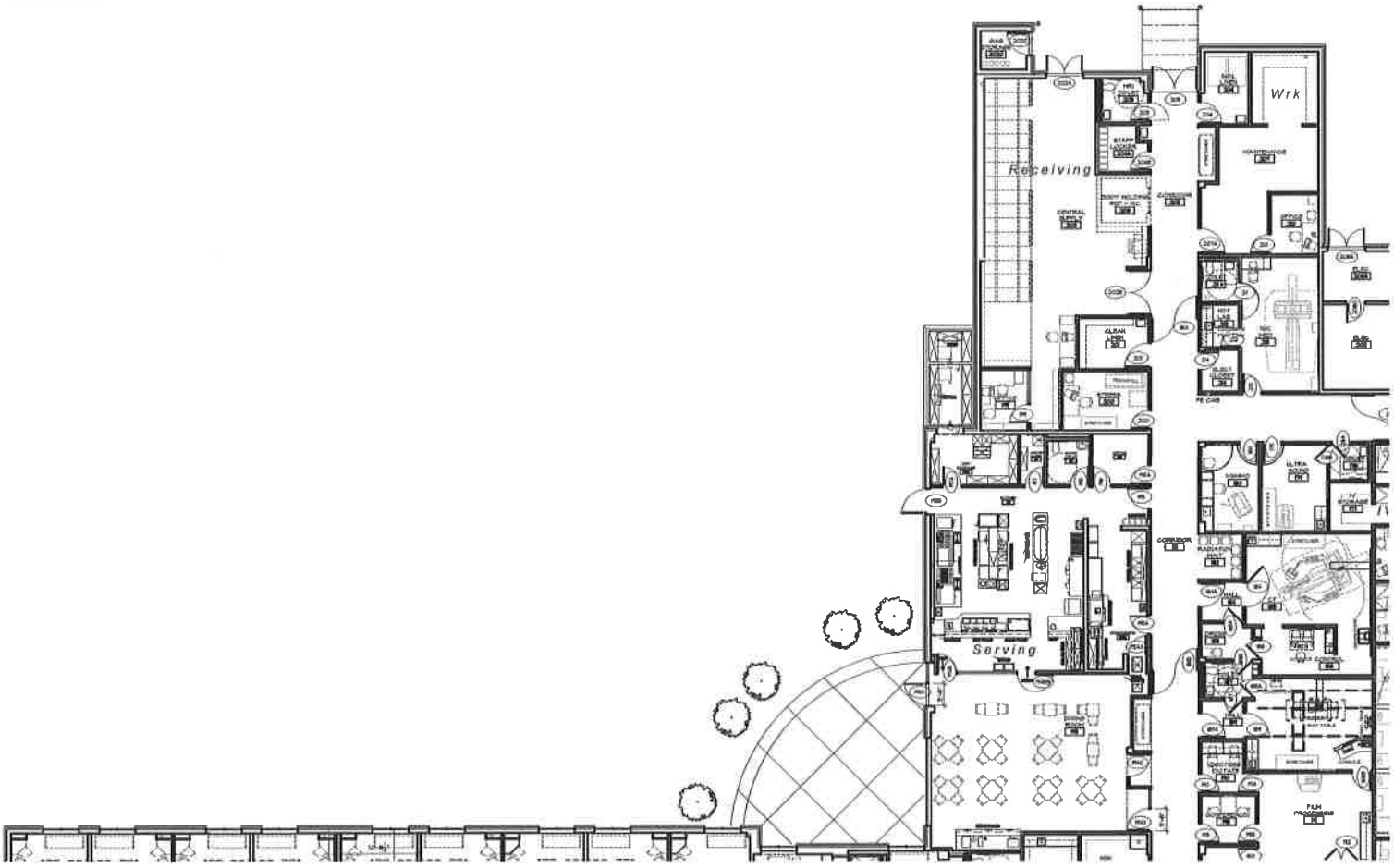
Attachment 6

Question 9- Section B, Item IV

Floor Plan

SUPPLEMENTAL #1
January 29, 2016
9:59 am

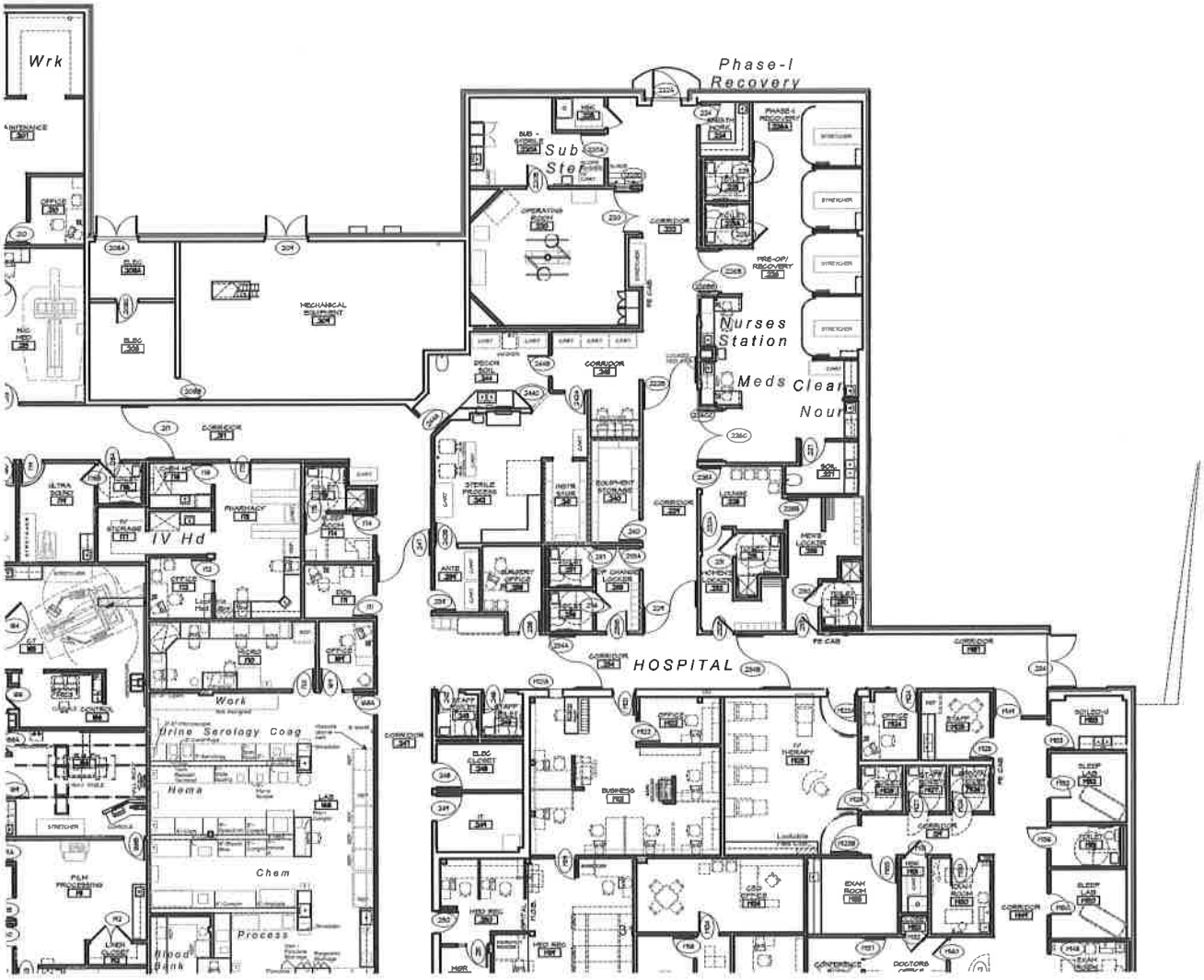
Attachment 6
Question 9- Section B, Item IV
Floor Plan



SUPPLEMENTAL #1

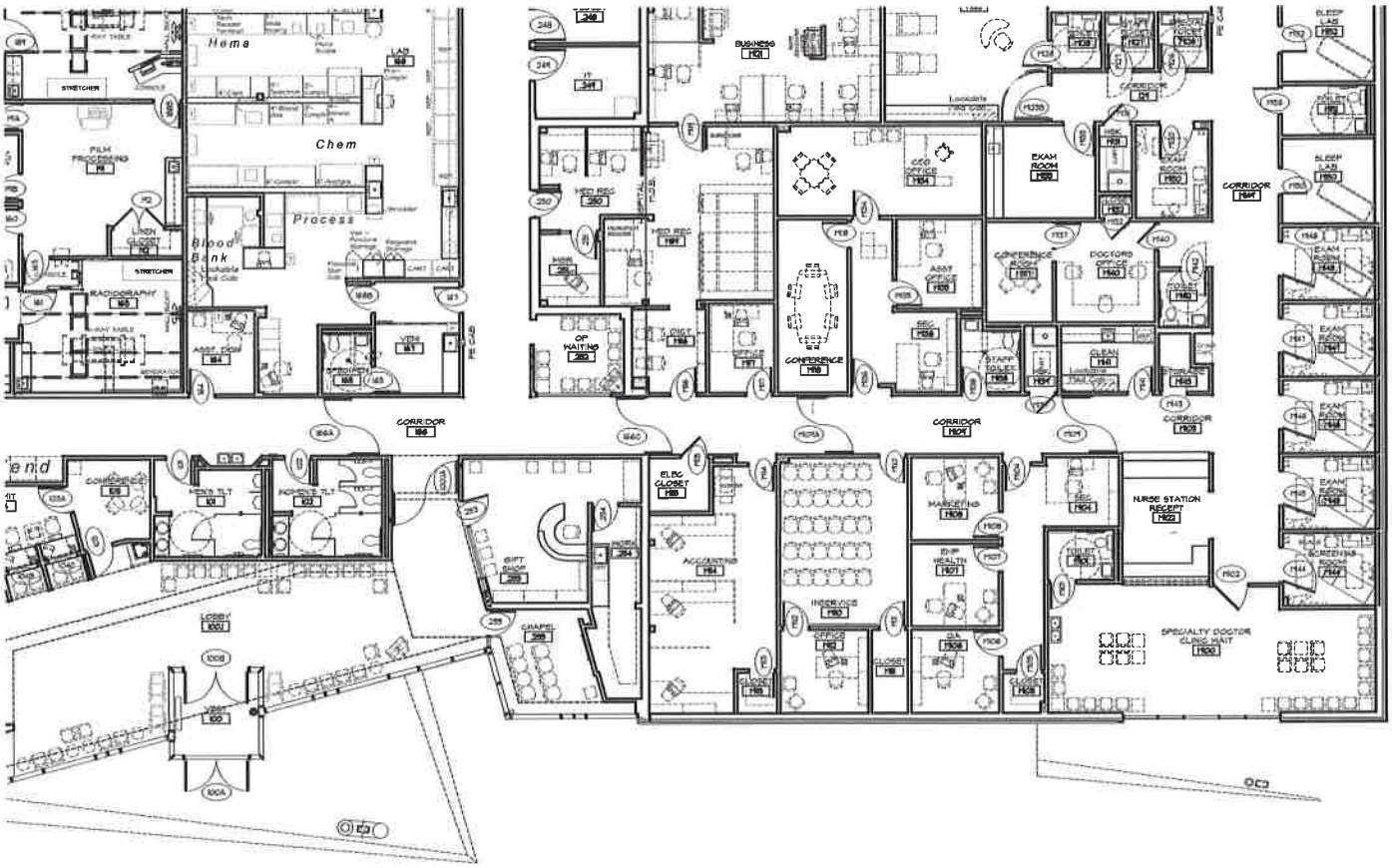
January 29, 2016

9:59 am



SUPPLEMENTAL #1

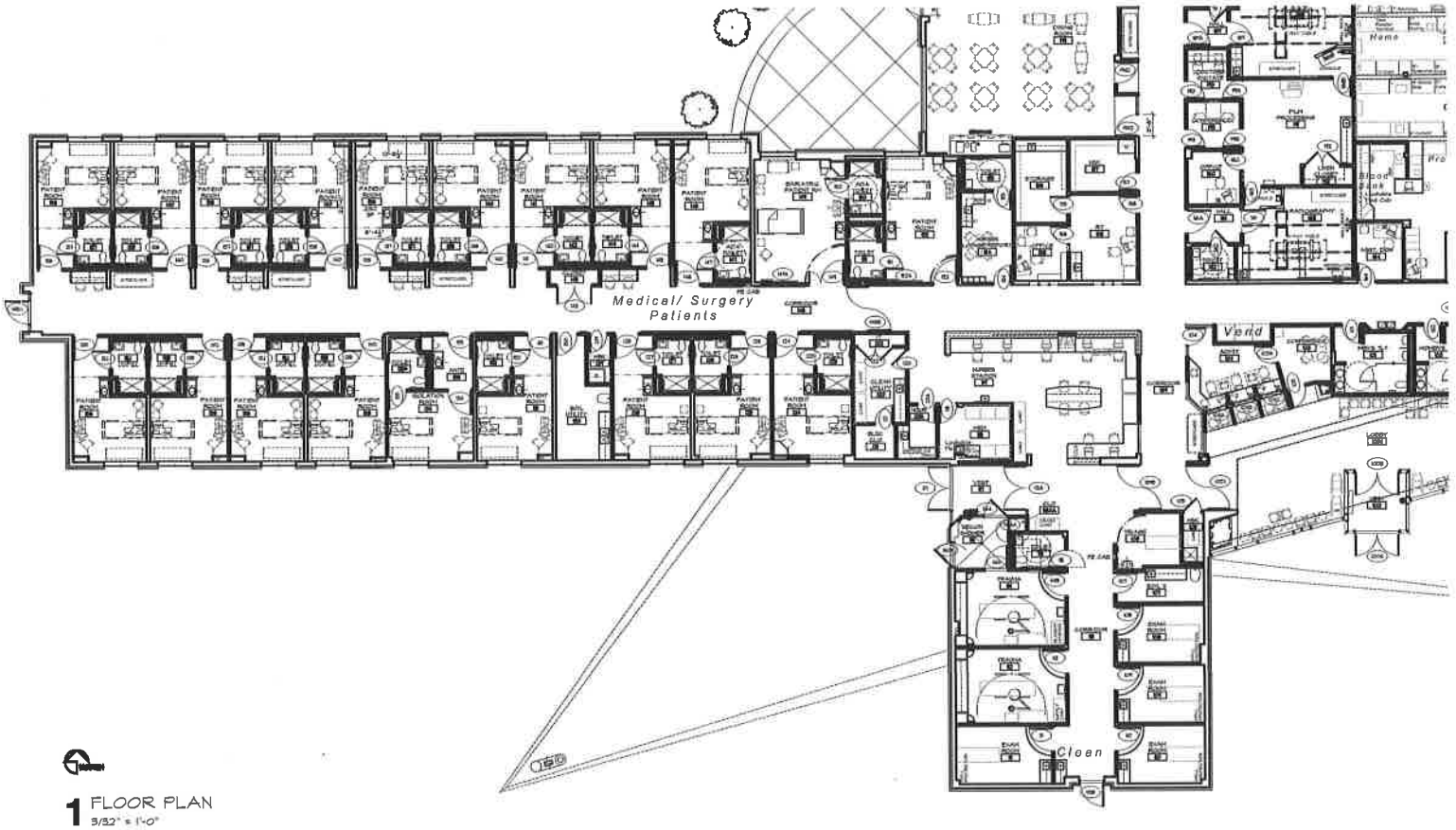
January 29, 2016
9:59 am



SUPPLEMENTAL #1

January 29, 2016

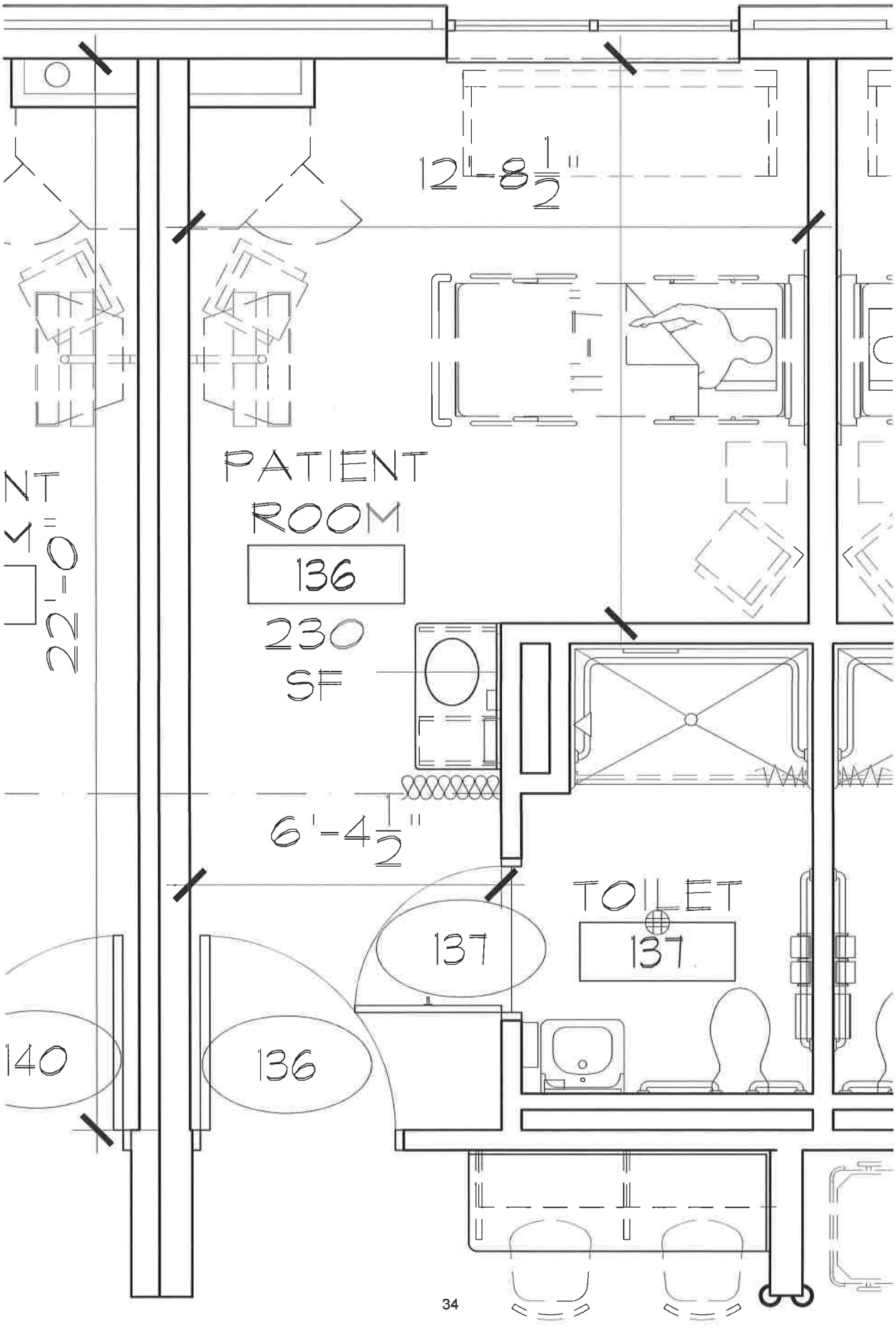
9:59 am



1 FLOOR PLAN
3/32" = 1'-0"

SUPPLEMENTAL #1

January 29, 2016
9:59 am



Lauderdale Community Hospital

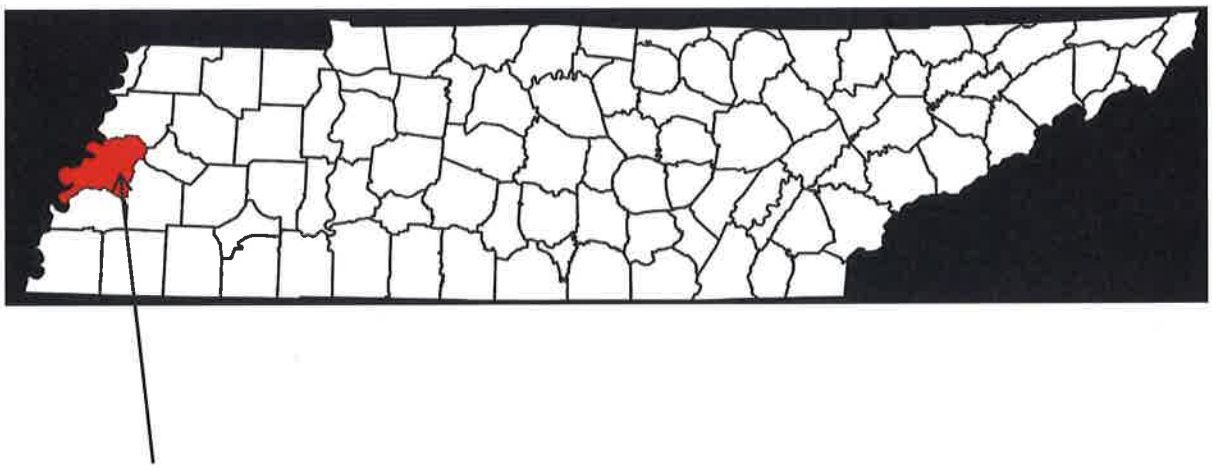
Tennessee Certificate of Need

Attachment 7

Question 11- Section C, Item 3

County Level Map of Tennessee

Attachment 7
Question 11- Section C, (Need), Item 3
County Level Map of Tennessee



Lauderdale County, Tennessee

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 8

Question 13- Section C, Economic Feasibility, Item 1

Facility Appraisal

Attachment 8
Question 13, Section C, Economic Feasibility, Item 1
Facility Appraisal

SUMMARY OF SALIENT FACTS

Property	Baptist Memorial Hospital – Lauderdale 326 Asbury Avenue Ripley, Tennessee
Assessor's Parcel Number	094-027.04
Interest Appraised	Fee Simple Estate
Effective Date of Appraisal:	March 8, 2010
Date of Physical Inspection	March 8, 2010
Date of Report	March 8, 2010
Type of Value	To estimate the market value of the fee simple interest of the subject facility's going concern as of the date specified within this report.
Intended Use	In connection with conventional financing
Land Size	1,522,422 square feet, or 34.95 acres (per county assessor)
Zoning	H-1 (Hospital and Medical)
Building Description	The improvements include a one-story, approximately 80,000-square-foot, critical access hospital built in 1982 that contains 25 acute-care and 10 geriatric psychiatric beds. The quality of construction and the condition of the improvements are average.
Licensing	25 beds (Pediatric Basic and Critical Access) 10 beds (Geriatric Psychiatric)
Highest and Best Use:	
As Vacant	Medically related use
As Developed	Continue use as is

Value Indicators:

Cost Approach	
Land	$120,000
Improvements	9,700,000
Equipment	1,620,470
Value Indication	$11,440,470
Sales Comparison Approach	
Value Indication	$3,890,000
Income Capitalization Approach	
Adjusted Patient Days	4,563
EBITDA	$707,332
Capitalization Rate	18.0%
Value Indication (rounded)	$3,930,000
Value Conclusion - Fee Simple	$3,930,000

This value may be allocated as follows:

Land	$120,000
Improvements	2,189,530
Equipment	1,620,470
Business	0
Total	$3,930,000

Special Limiting Conditions:

It is assumed that the subject is efficiently managed, with proven and ready operations, and is an established business.

In arriving at the opinion expressed in this report, we assumed that the title to the property is free and clear and held under responsible ownership. Management is considered to be a competent and professional healthcare provider.

Some of Management's assumptions inevitably may not materialize and unanticipated events and circumstances may occur. Therefore, actual results achieved may vary from Management's forecasts and the variations may be material.

Historical operating data was provided by the owner. It is assumed this financial data is correct and will accurately reflect the operating performance of the subject property. Otherwise, our valuation conclusions may be subject to change.

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 9

Question 13- Section C, Economic Feasibility, Item 1

Project Costs Chart

SUPPLEMENTAL #1

January 29, 2016
9:59 am

Attachment 9
Question 13, Section C, Economic Feasibility, Item 1
Project Costs Chart

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	1,145,147
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	0
3.	Acquisition of Site	0
4.	Preparation of Site	1,290,053
5.	Construction Costs	14,023,308
6.	Contingency Fund	1,190,952
7.	Fixed Equipment (Not included in Construction Contract)	0
8.	Moveable Equipment (List all equipment over $50,000)	0
9.	Other (Specify)	0
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	0
2.	Building only	0
3.	Land only	82,321
4.	Equipment (Specify)	0
5.	Other (Specify)	0
C.	Financing Costs and Fees:	
1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve for One Year's Debt Service	2,350,000
4.	Other (Specify)	0
D.	Estimated Project Cost (A+B+C)	20,081,781
E.	CON Filing Fee	44,999
F.	Total Estimated Project Cost (D+E)	20,126,780
	TOTAL	20,126,780

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 10

Question 13- Section C, Economic Feasibility, Item 1

Construction Documentation

JE DUNN CONSTRUCTION
1 LOCUST STREET
KANSAS CITY, MO 64106
TEL 816.474.8600 | FAX 816.391.2510
www.jedunn.com

January 25, 2016

Mr. Larry Arthur
Rural Community Hospitals of America, LLC
1100 Main Street Suite 2350
Kansas City, MO 64106

Re: Lauderdale Community Hospital – Ripley, TN

Dear Larry,

We are pleased to be working on the Lauderdale Community Hospital project in Ripley TN. We will construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specification and requirements. Attached you will find the preliminary budget breakdown, qualification, schedule and projected cash flow. The project is being designed by ACI/Boland/FSC, Inc. and Bob D. Campbell. We anticipate and 150-180 day process for design, bidding and permitting through CON. We anticipate a 3rd quarter, 2016 construction start.

We appreciate the opportunity to submit this budget proposal and look forward to providing our services on this project.

Feel free to contact me if you have any questions or comments.

JE DUNN CONSTRUCTION

Joseph L. Cisper

CC: File
Jeff Yartz
Rob Clevenger
Jim R. Miller

Sum

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

Construction Cost Summary

Description	Quantity	Cost	Unit Cost
Sitework	150 Cars	1,290,053	8,575
Medical Facility	46,851 SF	13,024,282	277.99
Construction Subtotal	46,851 SF	14,314,335	$305.53
Design Fees & Reimbursables	8%	1,145,147	24.44
Design Contingency	4%	618,379	13.20
Construction Contingency	4%	572,573	12.22
Escalation to 3rd Qtr 2016	6%	999,026	21.32
Total Construction Cost	**46,851 SF**	**$17,649,461**	**$376.71**

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

Sitework

Item	Description	Cost
1	General Requirements	86,434
2	Excavation and Grading	409,337
3	Asphalt Paving	162,944
4	Concrete Work	77,221
5	Site Structures	0
6	Fencing	0
7	Specialty Paving	20,149
8	Signage and Striping	16,555
9	Site Specialties	29,292
10	Site Utilities	40,992
11	Storm Drainage Systems	66,517
12	Fire Protection	51,059
13	Landscaping and Irrigation	89,551
14	Electrical	141,160
	Subtotal	1,191,210
	Permits, Bonds and Insurance	37,412
	Contingency	0
	Escalation	0
	Fee	61,431
	Total	**$1,290,053**

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

1 Story Hospital
37,610 SF

Item	Description	Cost	Cost/SF
1	General Requirements	745,833	19.83
2	Excavation	96,694	2.57
3	Building Structure	910,847	24.22
4	Building Skin	260,933	6.94
5	Interior Masonry	0	0.00
6	Rough Carpentry	111,573	2.97
7	Finish Carpentry and Millwork	421,577	11.21
8	Membrane Roofing	260,191	6.92
9	Sheet Metal	47,920	1.27
10	Caulking and Dampproofing	63,955	1.70
11	Doors, Frames and Hardware	363,287	9.66
12	Glass and Glazing Systems	244,366	6.50
13	Plaster and Drywall Systems	707,790	18.82
14	Stone and Tile	44,836	1.19
15	Ceilings	169,738	4.51
16	Flooring	235,502	6.26
17	Painting	80,869	2.15
18	Specialties	175,425	4.66
19	Equipment and Furnishings	167,158	4.44
20	Special Construction	67,005	1.78
21	Elevators	0	0.00
22	Fire Protection	6,765	0.18
23	Plumbing	1,483,853	39.45
24	HVAC Systems	2,047,123	54.43
25	Electrical	1,565,678	41.63
	Subtotal	10,278,919	273.30
	Permits, Bonds and Insurance	322,823	8.58
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	530,087	14.09
	Total	**$11,131,829**	**$295.98**

Skin/Floor Area Ratio	41%	Total Skin Cost, Contact Area	$46.50 /SF
Glass/Skin Area Ratio	23%	Skin Cost, Bldg Area	$13.44 /SF

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
Concept Estimate

1 Story Medical Building
9,241 SF

Item	*Description*	*Cost*	*Cost/SF*
1	General Requirements	126,794	13.72
2	Excavation	26,315	2.85
3	Building Structure	233,552	25.27
4	Building Skin	63,703	6.89
5	Interior Masonry	0	0.00
6	Rough Carpentry	29,658	3.21
7	Finish Carpentry and Millwork	102,366	11.08
8	Membrane Roofing	78,658	8.51
9	Sheet Metal	10,827	1.17
10	Caulking and Dampproofing	14,719	1.59
11	Doors, Frames and Hardware	98,289	10.64
12	Glass and Glazing Systems	51,700	5.59
13	Plaster and Drywall Systems	180,436	19.53
14	Ceramic Tile	0	0.00
15	Ceilings	43,229	4.68
16	Flooring	47,334	5.12
17	Painting	20,411	2.21
18	Specialties	15,016	1.62
19	Equipment and Furnishings	5,956	0.64
20	Special Construction	0	0.00
21	Elevators	0	0.00
22	Fire Protection	27,535	2.98
23	Plumbing	158,085	17.11
24	HVAC Systems	189,702	20.53
25	Electrical	223,170	24.15
	Subtotal	1,747,455	189.10
	Permits, Bonds and Insurance	54,881	5.94
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	90,117	9.75
	Total	**$1,892,453**	**$204.79**

Skin/Floor Area Ratio	38%	Total Skin Cost, Contact Area	$48.93 /SF
Glass/Skin Area Ratio	14%	Skin Cost, Bldg Area	$12.49 /SF

SUPPLEMENTAL #1
January 29, 2016
9:59 am

ACI BOLAND ARCHITECTS

ACI/BOLAND, INC. – KANSAS CITY
1421 E 104th Street, Suite 100
Kansas City, Missouri 64131
T.816.763.9600
F.816.763.9757

January 26, 2016

Mr. Larry Arthur
Rural Community Hospitals of America, LLC
1100 Main Street Suite 2350
Kansas City, MO 64106

Re: Lauderdale Community Hospital – Ripley, TN

Dear Larry:

We look forward to working with you on the hospital replacement project at Lauderdale Community Hospital. As you are aware, we attest that our design will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the latest AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

Should you need any further information from me during this process please feel free to contact me directly.

Sincerely,

ACI BOLAND, Inc.

Victor L. Mosby,
Principal / Architect

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 11

Question 14- Section C, Economic Feasibility, Item 2

Funding Documentation

Attachment 11
Question 14, Economic Feasibility, Item 2
Funding Documentation

CFG CAPITAL MARKETS, LLC
MEMBER FINRA/SIPC

January 27, 2016

Jim Shaffer, President
CAH Acquisition Company 11 LLC
d/b/a, Lauderdale Community Hospital
1100 Main, Suite 2350
Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,

CFG Capital Markets, LLC, ("CFGCM") appreciates the opportunity to work with you on the proposed $23,000,000 replacement of the Lauderdale Community Hospital in Ripley, Tennessee. This letter confirms our engagement to facilitate the development of the replacement facility including identifying commercial banks to provide construction financing based on current markets conditions. Based on our discussions with lending sources to date, we believe there is debt financing available for the development of the replacement facility.

We believe lending institutions will provide up to 75% of project costs (approximately $17.25 million) with the New Market Tax Credits and equity accounting for the balance. The terms of the debt will depend on the institution providing the loan, but should generally reflect a seven-year term to mirror the New Market Tax Credit component and the interest rate should generally range between LIBOR plus 350 to 450.

The commitment to provide the debt financing will be subject to customary underwriting and due diligence of the lender, including, but not limited to:

- Obtaining all necessary entitlements and approvals, including the Certificate of Need;
- Third party reports;
- Lender site visit; and
- Lender underwriting criteria.

We, and the initial lenders we have spoken to, believe this project is highly desirable based on the performance of the current facility.

CFGCM is not itself a lending institution, but based on our deep ties in the lending community for healthcare facilities, we believe the debt financing can be obtained. We look forward to working with you and your team to assist you with the development of this replacement Critical Access Hospital.

Sincerely,

Samer S. Tahboub
Director
CFG Capital Markets, LLC

SUPPLEMENTAL #1
January 29, 2016
9:59 am

CHHS
Community Hospitality Healthcare Services

January 8th, 2016

Jim Shaffer, President
CAH Acquisition Company 11, LLC
d/b/a Lauderdale Community Hospital
1100 Main, Suite 2350
Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,
Community Hospitality Healthcare Services has received an array of information regarding the proposed replacement of the Lauderdale Hospital facility located in Ripley, Tennessee. As a federally certified "Community Development Entity" (CDE) by the CDFI Fund at the US Treasury with a national footprint, we would be interested in providing a sub-allocation of New Markets Tax Credits to the project. With a focus on healthcare infrastructure and job creation in distressed communities, we have funded dozens of projects with similar attributes. The project is located in a highly qualified census tract within a rural community. Based upon the geography and initial estimates of community impacts, including creation of quality jobs and services provided to the community, the project meets our initial thresholds for underwriting. Receipt of final NMTC investment from CHHS is contingent upon:

-Obtaining all necessary entitlements and approvals required by law, including Certificates of Need;
-Securing first-lien debt and additional capital sources required to fully fund the project;
-Collection of additional transaction diligence items;
-Availability of allocation at the time the project is ready to commence closing process; and
-Final underwriting and approval.

We anticipate that the NMTC investment will provide up to 23% (approximately $3 million) of the capital required to complete the project, in the form of a subordinated interest-only note with a term of no less than 7 years at an interest rate in the 2.5-3% range. We look forward to working with you on this highly impactful project.

Sincerely,

Benjamin Cirka
Executive Director
Community Hospitality Healthcare Services

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 12

Question 16- Section C, Economic Feasibility, Item 4

Historical and Projected Data Charts

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in OCTOBER (Month).

		Year 2013	Year 2014	*Year 2015*
A.	Utilization Data (Patient Days)	2,398	2,347	*2,189*
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 6,862,824	$ 5,450,236	*$ 5,789,102*
2.	Outpatient Services	24,086,893	27,208,705	*27,848,838*
3.	Emergency Services	7,724,520	6,696,963	*7,834,002*
4.	Other Operating Revenue (Specify) Cafeteria, Med Records, MCR HER, Grant Income	$ 522.385	$ 615,350	*$ 500,784*
	Gross Operating Revenue	**$ 39,196,622**	**$ 39,971,254**	**$ 41,972,726**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$ 19,817,700	$ 20,231,496	*$ 23,976,735*
2.	Provision for Charity Care	837,130	176,674	*274,237*
3.	Provisions for Bad Debt	3,415,875	3,835,255	*2,843,619*
	Total Deductions	**$ 24,070,705**	**$ 24,243,426**	**$ 27,094,591**
NET OPERATING REVENUE		**$ 15,125,917**	**$ 15,727,828**	**$ 14,878,135**
D.	Operating Expenses			
1.	Salaries and Wages	$ 5,884,252	$ 6,141,906	*$ 6,244,450*
2.	Physician's Salaries and Wages	150,611	150,412	*43,187*
3.	Supplies	1,250,825	1,301,259	*1,279,405*
4.	Taxes	152,790	134,180	*120,055*
5.	Depreciation	915,401	989,069	*849,949*
6.	Rent	0	0	*0*
7.	Interest, other than Capital	80,431	69,960	*103,759*
8.	Management Fees:			
	a. Fees to Affiliates	_____	_____	_____
	b. Fees to Non-Affiliates	1,413,991	1,419,996	1,618,373
9.	Other Expenses – Benefits, Med Specialist Fees, Purchased Services, Leases, Licenses, Utilities, Property Tax	4,956,309	4,019,391	*4,287,163*
	Total Operating Expenses	**$ 14,804,610**	**$ 14,226,173**	**$ 14,426,286**
E.	Other Revenue (Expenses) – Net (Specify)_____	$ 0	$ 0	*$ 0*
NET OPERATING INCOME (LOSS)		**$ 321,307**	**$ 1,501,655**	*$* **451,849**
F.	Capital Expenditures			
1.	Retirement of Principal	$ 435,016	$ 605,887	*$ 1,002,827*
2.	Interest	322,017	318,794	*122,062*
	Total Capital Expenditures	**$ 757,033**	**$ 924,681**	*$* **1,124,890**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ (435,726)**	**$ 576,974**	**$(673,041)**

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in October (Month).

		Year_2018_	Year_2019_
A.	Utilization Data (Patient Days)	2,427	2,524
B.	Revenue from Services to Patients		
1.	Inpatient Services	6,940,971	7,435,168
2.	Outpatient Services	34,395,985	36,642,245
3.	Emergency Services	8,572,030	9,005,774
4.	Other Operating Revenue (Cafeteria, Med Records, HER, MCR, Grant Income)_	448,828	448,828
	Gross Operating Revenue	**50,357,814**	**53,532,015**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	27,499,852	29,355,003
2.	Provision for Charity Care	330,028	351,017
3.	Provisions for Bad Debt	4,940,990	5,255,236
	Total Deductions	**32,770,870**	**34,961,256**
NET OPERATING REVENUE		**17,586,944**	**18,570,759**
D.	Operating Expenses		
1.	Salaries and Wages	5,530,704	5,710,700
2.	Physician's Salaries and Wages	0	0
3.	Supplies	1,758,823	1,857,205
4.	Taxes	0	0
5.	Depreciation	1,277,778	1,277,778
6.	Rent	0	0
7.	Interest, other than Capital	42,674	42,674
8.	Management Fees:		
	a. Fees to Affiliates	0	0
	b. Fees to Non-Affiliates	1,934,706	2,042,925
9.	Other Expenses – Benefits, Purch Svcs, Benefits, Other Op	4,350,037	4,567,090
	Total Operating Expenses	**14,894,722**	**15,498,372**
E.	Other Revenue (Expenses) -- Net (Specify)_____	0	0
NET OPERATING INCOME (LOSS)		**2,692,222**	**3,072,388**
F.	Capital Expenditures		
1.	Retirement of Principal	638,677	636,573
2.	Interest	2,045,333	1,990,877
	Total Capital Expenditures	**2,684,010**	**2,627,450**
NET OPERATING INCOME (LOSS)			

LESS CAPITAL EXPENDITURES	**8,212**	**444,938**

SUPPLEMENTAL #1
January 29, 2016
9:59 am

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	*Year 2015*
1. BENEFITS	$ 1,338,183	$ 1,424,873	*$ 1,367,552*
2. MEDICAL SPECIALIST FEES	656,572	655,464	*687,866*
3. PURCHASED SERVICES	878,541	871,526	*695,203*
4. Utilities	491,886	465,095	*432,071*
5. Leases	73,345	54,651	*329,112*
6. Insurance Expense	371,371	425,422	*455,184*
7. Licenses, Repairs & Maint, Dues, Chapter 11, et al	1,146,411	122,360	*320,175*
Total Other Expenses	**$ 4,956,309**	**$ 4,019,391**	***$ 4,287,163***

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Benefits	1,372,160	1,471,506
2. Medical Specialist Fees	730,497	745,107
3. Purchased Services	629,263	641,848
4. Utilities	258,395	266,147
5. Leases	396,066	421,256
6. Insurance Expense	547,786	582,625
7. Licenses, Repairs and Maint, Dues, et al	415,870	438,601
Total Other Expenses	**4,350,037**	**4,567,090**

SUPPLEMENTAL #1
January 29, 2016
9:59 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 13

Question 22- Section C, Orderly Development, Item 7(d)

Last Survey by the Tennessee Dept of Health

Attachment 13
Question 22- Section C, (Orderly Development), Item 7(d)
Last Survey by the Tennessee Dept of Health

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305
(731)984-9684

June 21, 2011

Mr. Scott Tongate, Administrator
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: Licensure Survey

Dear Mr. Tongate:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey completed at your facility on **June 15, 2011**. The attached form is for your files.

If this office may be of any assistance to you, please do not hesitate to call (731) 984-9711.

Sincerely,

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CS/TW

Enclosure

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53188A	A. BUILDING _____ B. WING _____	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUDERDALE COMMUNITY HOSPITAL	326 ASBURY AVENUE RIPLEY, TN 38063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 002	1200-8-1 No Deficiencies This Rule is not met as evidenced by: Based on record review, observation and interview, the facility was found in compliance with State requirements for Hospitals. No deficiencies were cited during this annual licensure survey.	H 002		

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

SUPPLEMENTAL #1
January 29, 2016
9:59 am

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305
(731)984-9684

June 21, 2011

Mr. Scott Tongate, Administrator
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: PECU Licensure Survey

Dear Administrator:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey conducted at your facility on **June 15, 2011.** The attached form is for your files.

If this office may be of any assistance to you, please do not hesitate to call (731) 984-9684.

Sincerely,

Celia Skelley

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CS/TW

Enclosure

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53188A	A. BUILDING _____ B. WING _____	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUDERDALE COMMUNITY HOSPITAL	326 ASBURY AVENUE RIPLEY, TN 38063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 002	1200-8-30 No Deficiencies This facility complies with all requirements for participation as BASIC level in the Pediatric Emergency Care Unit program. No deficiencies were cited during the annual licensure survey conducted on 6/15/11.	P 002		

SUPPLEMENTAL #1
January 29, 2016
9:59 am

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305

June 21, 2011

Mr. Scott Tongate, Administrator
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: Fire Safety Licensure Survey

Dear Mr. Tongate:

Enclosed is the statement of deficiencies for the fire safety licensure survey completed at your facility on **June 15, 2010.** Based upon 1200-8-1, you are asked to submit an acceptable plan of correction for achieving compliance with completion dates, and signature **10 days from the date of this letter.**

Please address each deficiency separately with positive and specific statements advising this office of a plan of correction that includes acceptable time schedule, which will lead to the correction of the cited deficiencies. Enter on the right side of the State Form, opposite the deficiencies, your planned action to correct the deficiencies and the expected completion date. The completion date can be no longer than **45 days from the day of survey.** Before the plan can be considered "acceptable," it must be signed and dated by the administrator

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-984-9711.

Sincerely,
Celia Skelley
Celia Skelley, MSN, RN
Public Health Consultant Nurse 2
CS/TW

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53188A	A. BUILDING 77 - LICENSE B. WING _____	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUDERDALE COMMUNITY HOSPITAL	326 ASBURY AVENUE RIPLEY, TN 38063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 900	1200-8-1-.09 Life Safety This Rule is not met as evidenced by: 2-3.5.1* In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. Detectors should not be located in a direct airflow nor closer than 3 ft (1 m) from an air supply diffuser or return air opening. Supply or return sources larger than those commonly found in residential and small commercial establishments can require greater clearance to smoke detectors. Similarly, smoke detectors should be located farther away from high velocity air supplies. Based on observation, it was determined that the facility failed to maintain the required space between smoke detectors and air supply and air return openings. The findings included: Observation of the facility on 6/15/11, revealed a smoke detector inside the surgery hallway too close to the air supply diffuser; a smoke detector outside the anesthesia office too close to the air supply diffuser, and a smoke detector inside the radiology entrance was too close to the air return diffuser.	H 900		
H 902	1200-8-1-.09 (2) Life Safety (2) The hospital shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift	H 902		

PRINTED: 06/21/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53188A	A. BUILDING 77 - LICENSE B. WING _____	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUDERDALE COMMUNITY HOSPITAL	326 ASBURY AVENUE RIPLEY, TN 38063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 902	Continued From page 1 for hospital personnel in each separate patient-occupied hospital building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information. Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. This Rule is not met as evidenced by: Based on document review, it was determined that the facility failed to conduct fire drills for all shifts. The findings included: During document review on 6/15/11, the facility failed to provide documentation that second shift fire drills had been conducted for the third and fourth quarter of 2010, and the first quarter of 2011.	H 902		

5. **Please identify the project's average gross charge, average deduction from operating revenue and average net charge.**

Table 9: Average Charges, Deductions and Net

Average Gross Charges, Deductions and Net	Actual			Projected	
	2013	2014	2015	2018	2019
Patient Days	2,398	2,347	2,189	2,427	2,524
Gross Charges	38,674,237	39,355,904	41,471,942	49,908,986	53,083,188
Deductions	24,070,705	24,243,426	27,094,591	32,770,870	34,961,256
Net Patient Revenue	14,603,532	15,112,478	14,377,351	17,138,116	18,121,932
Average Cost					
Gross Charges	16,128	16,769	18,946	20,564	21,031
Deductions	10,038	10,330	12,378	13,503	13,852
Net Patient Revenue	6,090	6,439	6,568	7,061	7,180

6. **A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

Since the proposed project does not involve the implementation of new services or additional beds, LCH does not anticipate an increase in charges other than normal inflationary increases of 3 percent and cost report adjustments that occur annually.

Please see Attachment 12 for LCH's current allowable reimbursement letters from the hospital's Medicare Intermediary.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

There are no similar facilities to LCH in the service area or adjoining service areas. LCH is a Critical Access Hospital and is reimbursed based upon costs that are adjusted annually by Medicare. In addition, there are no new proposed charges with this application.

7. **Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.**

As indicated in the Utilization Table and the Projected Data Chart, utilization rates will increase with a replacement facility. A replacement facility will mean a more efficiently designed configuration which will greatly enhance effectiveness of staff and providers.

SUPPLEMENTAL #1

January 29, 2016
9:59 am

(HMC/CAH Consolidated, Inc.) -for the period ending September 30, 2014

Capitalization (long-term debt to capitalization) ratio

Measures the proportion of debt financing in a business's permanent (long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions.	Long-Term Debt	Total Equity (Net Assets)	**Capitalization Ratio**
Capitalization Ratio Formula: (Long-term debt ÷ (Long-term debt + Total equity (net assets)) x 100)	$43,381,879	-$30,204,040	3.29

ORIGINAL
Supplemental- #2

CAH Acquisition Company 11, LLC

CN1601-004

SUPPLEMENTAL #2
February 23, 2016
9:32 am

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

February 2, 2016

Tammie Hardy
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: Certificate of Need Application CN1601-004
CAH Acquisition Company 11, LLC

Dear Ms. Hardy:

This will acknowledge our January 29, 2016 receipt of your supplemental response for a Certificate of Need for the construction and replacement of a 25 bed Critical Bed Access Hospital located at 326 Asbury Avenue, Ripley (Lauderdale County), TN 38063.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12 PM, Thursday February 11, 2016. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile Item 6**

   It appears the applicant will enter into an Option to Purchase Agreement or Lease Agreement. If so, please revise the response to question #6 and provide a replacement page 3R.

   See Replacement Page 3R and Attachment 1

2. **Section A, Applicant Profile Item 13**

   The applicant indicates being contracted with AmeriGroup and TennCare Select. However, the 2014 Joint Annual Report for the applicant indicates no inpatient revenue for either plan. Please clarify.

   The Amerigroup contract became effective 1/1/14. The state did not autoselect patients in the Lauderdale area into Amerigroup until 1/1/15. So, in 2015 the applicant should start seeing volume in Amerigroup.

   Tenncare Select is a very small portion of the Tenncare patient population in Lauderdale County. There is Tenncare Select volume in 2014, however it is outpatient only.

3. **Section B. I. Project Description and Applicant Profile Item 6**

The lease agreement is Attachment 3 in Supplemental #1 is noted. However, the applicant provided a lease agreement that is not fully executed and legally binding. Furthermore, the Lessor is left blank and not identified in the lease agreement. The applicant states in the supplemental response that a new company will be established during the construction period that will hold the lease (lessor).
Once the new company is established that will hold the lease, a copy of the partnership agreement, or corporate charter and certificate of corporate existence, if applicable, from the Tennessee Secretary of State is requested. Please also provide an ownership chart of the new company (lessor). A fully executed signed option to lease or lease agreement must be provided.

An executed copy of the Lease between the parties (i.e. Lessor and Lessee) is not yet available. In lieu thereof the applicant has provided a fully executed signed Lease Term Sheet which, among other things, gives the Lessee a series of options to lease the Project from the Lessor for an aggregate term of 30 years. You'll notice in the attached fully executed Lease Term Sheet that the project cost is listed as $23M. As you may recall, there is $3M of debt restructuring in addition to construction. We discussed this and agreed to go with the project cost at $20M despite this difference. See Attachment 1.

It appears that a copy of a fully executed joint venture agreement between all parties that will form the "NewCo" that will hold the lease agreement is needed to confirm site control of the project.

CBC Real Estate Group (CBC) will be the party that forms the new company (NewCo) as the wholly owned subsidiary of CBC. Lessor will hold the Lease and control the Property and the Project during the construction period. During the construction period, NewCo will act as the developer of the Project for CBC.

If the applicant, CAH Acquisition Company #11, LLC owns the 23.976 acre tract, then why is the applicant proposing to lease the 23+ acre tract from the lessor (to be named)?

The Project is structured as a build-to-suit lease transaction under which Lessor is obligated to construct the Project in accordance with LCH's plans and specifications. Upon final completion of the project, Lessor will lease the Property back to Lessee.

In order to accomplish a build-to-suit lease transaction of this type, LCH will (upon the signing of the Lease) deed and convey fee simple title to the 23+ acre tract to
Lessor. This conveyance will enable Lessor to perform its obligations under the Lease to construct the Project to LCH's plans and specifications and lease the Property back to Lessee.

It is noted CAH Acquisition Company #11, LLC holds the deed to the 35 acre property. Please provide a ground lease between CAH Acquisition Company #11, LLC and the lessor.

There will not be a ground (land only) lease involved in the Project. As noted above, the Project is structured as a build-to-suit lease transaction, under which the parties (i.e. the Lessor and the Lessee) sign an agreement (i.e. the Lease) leasing the Property and Project (i.e. both land and improvements) back to the Lessee.

In the lease agreement it is noted the CAH Management Company or affiliate will provide a corporate guaranty for lease payments of the facility. Please clarify.

HMC/CAH Consolidated, Inc., a Delaware for profit corporation ("HMC") is the sole member of LCH (the applicant) and will provide a corporate guaranty to Lessor of the payments and obligations under the Lease.

It is noted that at closing of the lease transaction, the lessee will convey fee title to the lessor. The lessee will leaseback Parcel 2 from the lessor. Is this included in the lease provided, or will there be a separate lease? If so, please provide.

The obligation of LCH to deed fee title to Lessor is stated in the Lease Term Sheet (Attachment 1) and this obligation will also be stated in the Lease.

Please provide a diagram reflecting the following for each phase of the proposed project: 1) funding, 2) development 3) turnkey transaction, and 4) final ownership of assets and operations.

See Attachment 2

4. **Section B. I. Project Description**

It is noted private rooms in the proposed bed newly constructed hospital will be 237 SF. However, the floor plan for room #136 indicates 230 SF. Please clarify.

230 SF is correct.

The 2014 Joint Annual Report indicates the current facility has a helipad. Please clarify if the existing helipad will be used for the new proposed facility.

No. A new helipad will be built as part of the new construction and the existing helipad will no longer be used.

The applicant provided a list of 12 HMC/CAH hospitals which filed for bankruptcy in the past. However, it appears there are 3 hospitals not listed (CAH Acquisition Co., LLC 13, CAH Acquisition Co., LLC 14, CAH Acquisition Co., LLC 15). What is the status of these hospitals?

When the Chapter 11 proceeding was filed in October 2011, HMC owned and operated only the 12 listed hospital subsidiaries. HMC has never owned and operated more than the 12 listed subsidiaries. HMC has never owned and operated any hospital subsidiaries numbered 13, 14 and 15.

5. **Section C. (Economic Feasibility) Item 1. (Project Cost Chart)**

The following definition regarding items acquired by lease in Tennessee Health Services and Development Agency Rule 0720-2-.01 (12)(d) states " If the acquisition is by lease, the cost is either the fair market value of the property, or the total amount of the lease payments, whichever is greater."

Please provide documentation of the fair market values of both the land and the building and the calculation of the total amount of the lease payments over the term of the lease. Please insert the greater amount in line B.1 of the Project Costs cost and resubmit a replacement page.

See Attachment 3 and requested replacement page

Escalation to 3rd Qtr. 2016 cost of $999,026 in the Construction Cost Summary located on page 45 of supplemental #1 is noted. However, please clarify where this cost is allocated in the Project Costs Chart.

The Escalation to 3rd Qtr 2016 cost of $999,026 was included on line A.5 (Construction Cost) of the Project Costs Chart. Or it was until the applicant changed the Project Costs Chart to represent total of lease payments (per previous question)

6. **Section C. (Economic Feasibility) Item 2. Funding**

The funding of 85% of project costs from CFG Capital Markets, LLC and 15% of the capital costs from Community Hospitality Healthcare Services (CHHS) is noted. However, the letter from CHHS notes up to 23%. Please clarify and revise if needed and provide a replacement page 23.

New Market Tax Credit (NMTC) is a program enacted by Congress to encourage private sector capital investment into low-income communities in order to stimulate economic development and create jobs. The NMTC program accomplishes these goals by offering tax credit-enhanced financing to qualified projects through qualified community development entities (CDEs). CDEs use standard industry lender underwriting and approval requirements.

The NMTC program is subject to an annual allocation of federal tax credits by Congress to CDEs.

CHHS is a qualified CDE and has been a NMTC industry leader for many years. CHHS receives annual allocations of tax credits from the NMTC program. CHHS states in its letter of support for the Project that the build-to-suit transaction described in the Lease Term Sheet meets its initial thresholds for underwriting. See Attachment 4.

CHHS further states that it anticipates providing tax credits from its NMTC allocation for FY2016 totaling up to 23% of Project cost. In this regard, it should be noted that in order to be conservative in its financing proposal for the Project, the applicant has included NMTCs totaling only 15% in the funding calculation for the Project.

Documentation on the NMTC program along with CHHS's estimate on the amount of tax credits that will be made available for the Project were attached to the original CON in the form of the support letter from CHHS as well as an overview of NMTC provided in answer to Question 5 (Section B.I.) of the Supplemental Submission. Both are attached to this Supplemental request as well. No replacement page 23 is required. See Attachment 4.

It is noted the New Markets Tax Credit represents $3,000,000 or 15% of the funding project. However, please clarify if the New Market Tax Credit is awarded in a competitive application process, or is it guaranteed. If the applicant is relying on financing $3,000,000 using New market Tax Credit, please provide a letter from the funding source guaranteeing $3,000,000 in New Market Tax Credit.

The NMTC process is indeed a competitive one, with certain criteria being required to qualify. However, based on CHHSs' experience with applying and getting these credits from the Federal Government, estimates are such that they will provide up to 23% of the

project cost. Documentation on this process along with CHHS conclusions on the amounts available for the project were attached to the original CON in Attachment 11 in the form of a letter from CHHS as well as the overview of NMTCs provided in answer to Question 5 (Section B.I.) of the Supplemental Submission. Both are attached to this Supplemental request as well. See Attachment 4

The letter from CFG (not a lending institution) regarding the $17.25 million to fund the project is noted. However, as prescribed in the Certificate of Need application, a letter is required from each lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions. Please provide.

While CFG is not a lending institution, they are facilitating the capital raise for this project. CBC is the lessor and developer and will be providing $17 million of the debt required for this project. CHHS is a lender and will be providing the remaining $3 million in the form of tax credits. Both CFG and CHHS have provided letters of intent which were attached to the original CON with revised copies attached to the Supplemental Questions #1. Also, please find the fully executed Term Sheet in Attachment 1 for clarification of these relationships.

7. **Section C. (Economic Feasibility) Item 4**

The applicant indicates there were 2,347 patient days in 2014 in the Historical Data Chart and 1,167 patient days in Table Six on page 20. However, the 2014 Joint Annual Report indicates there were 984 patient days in 2014. Please clarify.
If necessary, please revise and submit replacement pages.

The Joint Annual Report (JAR) is correct; there are 984 acute patient days in 2014. A replacement Historical Data Chart will be provided. The Historical Data Chart however, will not tie directly to the JAR. The JAR looks specifically at acute days; meanwhile the Historical Data Chart as well as all financial projections also take into consideration Swing Bed Days. The two together will give you the 2,164 days found on the revised Historical Data Chart. (984 + 1,180 = 2,164)

It is noted the applicant allocated $120,055 in the Historical Data Chart while the hospital experienced a loss of $673,041 in 2015. Please breakout the $120,055 tax expense and explain the reason why it was allocated.

The taxes shown on line 4 are not income taxes and therefore were not allocated. As stated previously, LCH is part of the HMC/CAH Consolidated tax return, which had no taxable income in 2014 or 2015. So no income taxes were allocated. Below please find a listing of the taxes in question.

Table1: Tax Expense Breakout

LCH CON HISTORICAL DATA					
Tax Breakout					
	Historical			Projected	
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Corporate Franchise Tax *	23,589	2,383	7,407	7,500	7,500
Property Tax	129,201	125,180	106,151	206,610	190,442
Sales Tax	-	6,617	6,497	6,500	6,500
Income Tax	-	479,059	150,053	261,990	438,012
TOTAL	152,790	613,239	270,108	482,600	642,454

Joint Annual Report for the applicant reflects $125,180 in local property taxes paid. Please include :

The 2014 Joint Annual Report for the applicant reflects $125,180 in local property taxes paid. Please include local property taxes in the Projected Data Chart for Year One and Year Two.

As you can see in Table 1 above, local property taxes have been included in the Historical Data Chart. Likewise, the Projected Data Chart has projected taxes (line d.4) of $482,600 and $642,454 in years one and two respectively. The projection of local property taxes is embedded in those two numbers. Please see replacement pages for the Historical and Projected Data Charts.

It is noted the hospital is part of the consolidated tax return which had no taxable income in 2014. It is also noted the applicant, CAH Acquisition Company 11, LLC, experienced $1,182,861 in net income in 2014. Please revise the Projected Data Chart by allocating tax expense for 2018 and 2019 to CAH Acquisition Company #11, then accounting for the offset of the tax expense. This will account for the taxable income expense and the offset of income taxes.

As you can see above in Table 1 and also in the replacement pages for the Historical and Projected Data Charts, An estimate for income taxes has been added. On the data charts, the taxes are included on line D.4 with the offset showing on Line E.

8. **Section C. (Economic Feasibility) Item 10.**

The Capitalization (long-term debt to capitalization) ratio table for HMC/CAH Consolidated, Inc. for the latest audited financial reporting year is noted. However, the ratio appears to be incorrect. It appears from the data provided the ratio calculates to 58.95. Please verify.

(HMC/CAH Consolidated, Inc.)- For the period ending 20XX.

Capitalization (long-term debt to capitalization) ratio

Measures the proportion of debt financing in a business's permanent (long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by	Long-Term Debt	Total Equity (Net Assets)	Capitalization Ratio

short-term financing decisions.			
Capitalization Ratio Formula: (Long-term debt ÷ (Long-term debt + Total equity (net assets)) x 100)	**$43,381,879**	**$-30,204,040**	**329.2**

According calculation for this ratio, it indicates that 329.2 is correct. 43,381,879 / (43,381,879 + (-30,204,040)) = 43,381,879 / 13,177,839 = 3.29 *100 = 329.2 The reservation with this calculation may be the presence of negative equity on the balance sheet. Because net equity is negative, the denominator, which normally adds debt to equity, is in effect subtracting equity. With the denominator being so much lower, we end up with an inflated ratio. The presence of negative equity on the balance sheet is related to many prior years of negative operating results; results that came during the years when HMC/CAH was turning around LCH and building a financially stable and profitable hospital that can properly service the Ripley, TN area into the future. Current profits are shrinking that equity figure and the applicant is confident that LCH will have positive equity in the future. The applicant believes that this ratio cannot be applied properly when negative equity exists as it artificially inflates the result. In addition, the ratio is meant as a predictor of future performance and given that the negative equity is representative of an unprofitable past that is no longer true, the applicant believes that this ratio should not be used.

The HMC/CAH Consolidated Inc. financial information for the year ending September 30, 2014 is noted. On page 190 of the report, it is noted 12 out of the 13 hospitals owned by HMC/CAH Consolidated, Inc. was operating at a net loss totaling $5,131,233. In addition, the only hospital owned by HMC/CAH Consolidated, Inc. that operated with net income for the year ending September 30, 2014 was the applicant, Lauderdale Hospital (CAH Acquisition Company 11, LLC), with $1,182,861. Please respond to the following:

- **Please identify and discuss the factors that made the applicant, Lauderdale Hospital (CAH Acquisition Company 11, LLC), more financially viable with net income of $1,182,861, from the other 12 hospitals which operated at a net loss.**

  Fiscal Year 2014 had some extraordinary items in it that affected the bottom line of all facilities, some more than others. HMC/CAH Consolidated emerged from bankruptcy in 2013 and because of this, no audit had been done during that time (2010 to 2013). As a result, 2014 had a lot of cleanup from prior years as well as one-time bankruptcy adjustments in it that were all booked in 2014 in anticipation of the applicant's first audit since 2010. The net result was lower than expected bottom lines. However, despite the bankruptcy and subsequent adjustments, HMC/CAH Consolidated still produced a positive EBITDA.

  However, there are several advantages that LCH enjoys over her sister facilities. First, LCH is a large hospital in comparison to most of the other facilities. LCH has 25 beds; meanwhile 8 of the 12 facilities have no more than 15 beds; so LCH is equipped to take more volume than the rest. LCH also has a primary service area without any direct competitors in it. The closest competitor is Baptist Memorial Hospital, which is approximately 20 miles away in Covington, TN. The primary service area also has a population topping 17,000; the next closest primary service area is no more than 10,000. LCH has our most active ER in the system and, up until lately,

our most prolific surgeon. Lastly, LCH is in Tennessee and Tennessee does more than any other state the applicant operates in to cover the medically indigent. Between the Tenncare program that covers the cost of Medicaid eligible patients and the Uncompensated Care Fund pool, LCH is better reimbursed for Medicaid and uninsured patients than most other facilities.

- **Please provide a date when HMC/CAH Consolidated, Inc. projects the corporation as a whole will operate with net income.**

  There are many variables, the largest of which is the timing regarding replacement facilities and the associated financing. In our latest projections, which assumes LCH replacement in 2016 as well as other facilities within the system throughout 2016-7, HMC/CAH Consolidated could see a small, positive net income in 2016. However, it would be 2018 before any significant bottom line gains would be seen. But these projections all assume no significant changes to Medicare and/or Medicaid reimbursement rates in the future. They also assume no major regulatory changes in the future. Based on the information available now, 2018 is projected to offer a positive net income.

  The applicant also feels that other factors need to be taken into account when contemplating future profitability with regard to HMC/CAH Consolidated. HMC/CAH was not created with the idea of operating hospitals in old, outdated buildings. The original business plan included replacing these facilities and capitalizing on the CAH program as illustrated in the Stroudwater Replacement Facility Study of 2011. Obviously this business plan was interrupted by the bankruptcy and only now is HMC/CAH getting back to their original plan. While replacing LCH is part of this plan, LCH's sister facility in Hillsboro, Ks has already closed on their financing and have started the construction process. Pending CON approval and closing on LCH, three more sister facilities await similar treatment behind LCH. It is the applicant's belief that HMC/CAH has turned the corner and will continue to see more profitability as more facilities are replaced.

9. **Section C. Orderly Development, Item 7.d.**

   Please provide a copy of the last accreditation survey conducted by Certificate of Accreditation by DNV GL-Healthcare.

   The latest accreditation survey was provided with the original CON as attachment 15. However, the applicant found out that the actual certificate itself was left out. As a result, it is included here in Attachment 5.

10. **Section C. Orderly Development, Items 8 and 9**

    There appears to be a recent civil judgement against CAH Acquisition 10, LLC (Yadkin Velley Community Hospital, Yadkinville, NC) and the parent company Rural Community of America, LLC. Please provide an overview of the civil judgement and amount of penalties assessed.

    HMC/CAH Consolidated, Inc. ("HMC") is the wholly owned subsidiary of CAH Acquisition Company 10, LLC ("CAH10").

In May 2010, CAH10 purchased from the County of Yadkin, North Carolina (the "County") the business and assets of *Hoots Memorial Hospital* which was located in Yadkinville, North Carolina (the "Hospital"). After the closing of the Hospital purchase, CAH10 renamed the Hospital - *Yadkin Valley Community Hospital*. The County retained ownership of the hospital building and improvements (the "Hospital Premises") and leased the Hospital Premises to CAH 10. The original Hospital lease was amended in 2012 and again in April 2013. In January 2013, CAH10 entered into a management agreement with Rural Community Hospitals of America ("RCHA"). At that time of the April 2013 amendment, the expiration date of the Hospital lease was extended to April 30 2015.

Prior to the end of the extended term, the County of Yadkin informed CAH 10 that it would not renew or extend the Hospital lease beyond the April 30, 2015 expiration date, because it wanted to replace CAH 10 with another hospital operator, Hugh Chatham Memorial Hospital ("Hugh Chatham"). In January 2015, CAH10 entered into negotiations with Hugh Chatham to sell to it the business and assets of the Hospital. During the first four months of 2015, the parties engaged in negotiations and due diligence.

As the April 30, 2015 lease expiration date approached with no sale agreement in place with Hugh Chatham, CAH 10 informed the County that it would need to issue the notice under the Worker Adjustment and Retraining Notification Act (WARN)), a United States labor law which protects employees and communities by requiring covered employers to provide 60 calendar-day advance notification of a closings and layoffs of employees. The notice stated that the hospital would close on April 30. The County refused to expend the Hospital lease and the WARN notice was issued on February 27, 2015.

Negotiations with Hugh Chatham continued and, on March 24, 2015, a non-binding term sheet for the sale of the Hospital business and assets was signed by CAH 10 and Hugh Chatham. The term sheet anticipated the sale of the hospital to occur by August 1, 2015. Thereafter, the County extended the Hospital lease through July 31, 2015 in order to allow the parties to finish the sale transaction contemplated by the March 24, 2015 term sheet. On April 16, 2015, Hugh Chatham (without explanation) ended negotiations with CAH10 and cancelled the term sheet.

In early May, 2015, CAH 10 put the County on notice that due to the loss in key managerial and clinical staff and the overall economic deterioration of the hospital, CAH10 might have to close the hospital prior to July 30, 2015. Attempts were made to negotiate a long term lease with the County but the County would not offer acceptable lease terms. Thereafter, CAH 10 attempted to transfer licensure and provider numbers to the County but it refused to accept the transfer.

In May, RCHA (in its capacity as the manager of the Hospital) made the decision to close the hospital due to patient safety concerns arising from the loss key personnel and the continuing deterioration of economic and clinical operations at the Hospital. On May 22, 2015, the North Carolina Department of Health visited the hospital and reviewed the plans to close the hospital and gave their approved of the plans. At approximately 6:00 p.m. on that day, RCHA closed the hospital.

Following the May 22, 2015 closure, the County filed a lawsuit seeking damages. CAH 10 and the other defendants (HMC and RCHA) are vigorously defending its position that the closure of the Hospital was, among other things, necessary to protect patient safety.

In accordance with Tennessee Code Annotated, §68-11-1607(c)(5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the

applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Resubmittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires and additional examination fee." For this application, the sixtieth (60th) day after written notification is March 21, 2016. If this application is not deemed complete by this date, the application will be deemed void. Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɜ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staffs are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart, HSD Examiner

PME
Enclosure

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

AFFIDAVIT

STATE OF MISSOURI

COUNTY OF JACKSON

Trent Skaggs, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed

appropriate by the Health Services and Development Agency are true and complete.

Trent Skaggs Exec VP
SIGNATURE/TITLE

Sworn to and subscribed before me this 18 day of Feb (Month), 2016 (Year) a Notary

Public in and for the County/State of Missouri.

Linda K. Way
Notary Public - Notary Seal
STATE OF MISSOURI
Jackson County
My Commission Expires: Nov. 17, 2018
Commission #14444354

Linda K. Way
NOTARY PUBLIC

My commission expires Nov 17 (Month/Day), 2018 (Year).

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

List of Attachments

Attachment 1	Fully Executed Term Sheet	Section A, Item 6
Attachment 2	Project Diagram	Section B, Item I
Attachment 3	Comparison of Fair Market Value to Total Lease Payments	Section C, Economic Feasibility, Item 1
Attachment 4	CHHS Letter of Intent and Overview	Section C, Economic Feasibility, Item 1
Attachment 5	Latest Certificate of Accreditation	Section C, Orderly Development, Item 7.d

List of Replacement Pages

Replacement Page 3R	Ownership Structure	Section A
Replacement Page	Project Costs Chart	Section C
Replacement Pages	Historical and Projected Data Charts	Section C

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 1

Question 1- Section A, Item 6

Fully Executed Term Sheet

CBC REAL ESTATE GROUP

LEASE TERM SHEET

January 1, 2016

This term sheet or letter of intent is not a binding agreement or gives rise to any legal liability between the parties, but is merely an expression of their intent with respect to the build-to-suit lease transaction ("Transaction") described below and sets forth preliminary negotiating points. For purposes of this letter agreement, the Transaction is defined as the development of an approximately $23,000,000 replacement critical access hospital in Ripley, Tennessee ("Project"). The agreement of the parties will only become binding upon the execution of a definitive lease agreement ("Lease") and other related agreements with respect thereto.

Lessee:	CAH Acquisition Company 11 LLC d/b/a Lauderdale Community Hospital ("LCH") or an affiliate to be formed and managed by LCH (collectively "Lessee"). LCH is the owner and operator of a critical access hospital in Ripley, Tennessee.
Lessor:	CBC Real Estate Group ("CBC") or a new company ("NewCo") to be formed and managed by CBC ("collectively "Lessor").
Deed of Property:	Upon the signing of the Lease, Lessee deeds to Lessor fee simple title to a tract of real property located at 326 Ashbury Avenue, Ripley, Tennessee 38063 consisting of 23.976 acres of land and a to be build-to-suit 25-bed replacement critical access hospital of approximately 46,000 square feet ("Property").
Lease of Property.	Upon the signing of the Lease, Lessor leases to Lessee the Property, and Lessee accepts the Property in "AS IS" condition. CBC appoints NewCo to act as the developer of the Project. Lessee works with Lessor to ensure that the Project is built and constructed in accordance with the plans, specifications, scope of work and schedule for approved by the parties and to ensure the adequacy and acceptability of the Project. Lessee shall provide its own inventory and supplies, FFE and other items not included in Lessor's scope of work. Lessor is not making any warranties or representations concerning the Property or the Project, or suitability for their intended use.
Lease Type:	The Lease shall be absolute net in nature whereby the Lessee shall be responsible throughout the term of the Lease for the payment of all amounts, liabilities, obligations and impositions related to the ownership, use, possession and operation of the Property, including, but not limited to, all utilities, all real estate taxes, insurance premiums, maintenance, repairs and capital

	improvements. This responsibility of the Lessee will be in addition to the payment of Base Rent (defined below).
Lease Term:	The Lease shall be for a term of nine (9) years. Lessee shall have one 6-year option and three 5-year renewal options.
Base Rent:	The annual rent ("Base Rent" for the first 12-month period following the issuance of a Certificate of Occupancy (the "CO") shall be an amount equal to 10.5% of the Transaction less an adjustment for New Market Tax Credits ("NMTC Adjustment"). The NMTC Adjustment is expected to equal to not less than $300,000 or 10% of the value received from the New Market Tax Credits currently contemplated for the Project. For avoidance of doubt, is it proposed the annual Base Rent for the first 12-month period following CO shall be $2,115,000 and shall be paid monthly in 12 equal amounts each year on the first (1st) day of each Lease month.
Facility Renovations:	From time to take time during the term of the Lease, Lessee shall have the right to modify and alter the Property as necessary subject to Lessor's approval of plans and the contractor which approval shall not be unreasonably withheld. Lessee shall obtain a payment and performance bond to ensure lien free completion of such alterations.
Adjustment of Rent:	Commencing on the date that is one year after the commencement of the Lease and each year thereafter, the annual Base Rent shall be increased by one and a half percent (1.5%). The annual Base Rent for the first year of each renewal option shall be the greater of: a) market rent, or b) 101.5% of the prior year's Base Rent. In either case, the annual Base Rent shall be subject to annual increases of 1.5% thereafter.
Use of Property:	Lessee covenants that it will obtain and maintain throughout the term of the Lease all approvals needed to use and operate the Property as a critical access hospital. Lessee covenants that during the term of the Lease it will continuously operate the Property only as a provider of healthcare services and shall maintain its certifications for reimbursement and licensure and all necessary accreditations.
Insurance Requirements:	Lessee covenants that it shall carry all forms of insurance coverage (e.g. GL/PL, Property, Earthquake, Flood, Wind, Business Interruption, Employee Dishonest/Theft, Auto, etc.) acceptable to Lessor's lender and loan Servicer including but not limited to coverage amounts and insurer rating. Lessor and Lessor's lender shall be named as an additional insured party on all Lessee policies.

Financial Statements:	Lessee covenants to provide monthly financials and audited annual financial statements to Lessor in a timely manner throughout the term of the Lease.
Lessee Repurchase Option:	So long as Lessee is not in default on the Lease, Lessee shall have the option, commencing on the date that is a minimum of 120 months after the closing of the Transaction and expiring at the end of 144 months following the closing of the Transaction, to repurchase the Property at a pre-established pricing methodology. The repurchase price shall be equal to the sum of the contractual rent payments to be received by Lessor for the immediate 12-month period after the repurchase date plus the annual NMTC Adjustment, divided by ten percent (10.0%). This purchase option is non-transferable.
Assignment and Subletting:	Lessee shall not assign the Lease or sublease any space in the Property without the prior written consent of Lessor.
Capital Improvement Obligation:	Lessee shall be required to make capital improvements and repairs to the Property and the physical plant of the Property in an amount equal to the minimum required by any lender in connection with consummating Lessor's financing or refinancing of the Project. Proof of such expenditures shall be provided at the end of each Lease year or upon request. Lessee shall timely complete at its own expense all repairs and replacements required by any lender in connection with consummating Lessor's financing or refinancing of the Project.
Events of Default:	Events of default by Lessee shall include all standard and customary events, including, but not limited to, failure to pay Base Rent, failure to pay real estate taxes, bankruptcy filing, loss of necessary licensing, abandonment, etc.
Events of Performance Default:	The Lease shall contain industry standard and customary coverage covenants to secure financing or refinancing of the Project.
Guaranty & Security:	HMC/CAH Consolidated, Inc. ("Guarantor") will provide a corporate guaranty for payments and obligations of Lessee. Subject to Lessor's review of the corporate financials, additional guarantor(s) may be required. Lessor will receive a security interest in all Lessee's assets and personal property at the Property. In addition, Lessee shall be required to fund an amount equal to six month's Base Rent as security deposit paid into the account in 48 equal monthly payments beginning at the start of the Lease. The security deposit

	shall be increased every three years based on the then current Base Rent.
Covenants:	The Lease shall contain industry standard and customary financial covenants to secure financing or refinancing of the Project.
Cooperation & Compliance With Lessor Financing:	Lessee, shall execute such documentation as is typically required by Lessor's lender (government agency or a private lender), including but not limited to a Lessee Regulatory Agreement, Deposit Control Agreements, SNDAs, Estoppel certificates, Subordination of Management Agreement, and Intercreditor Agreements with Lessee's Accounts Receivable Lender. Lessee shall be responsible for all expenses in connection with its own review of the aforesaid documentation.

In addition, to the terms laid out above, the Lease shall include all standard and customary language and agreements regarding casualty and loss, condemnation, insurance proceeds, Lessee's personal property, indemnification, quiet enjoyment, etc.

Dated as of the day and year written above.

Lessor:

CBC REAL ESTATE GROUP

By: _____

Mike Belew
Executive Vice President of Development

Lessee:

CAH ACQUISITION COMPANY 11 LLC

By: _____

Jim Shaffer
President

Guarantor:

HMC/CAH CONSOLIDATED, INC.

By: _____

Jim Shaffer
President

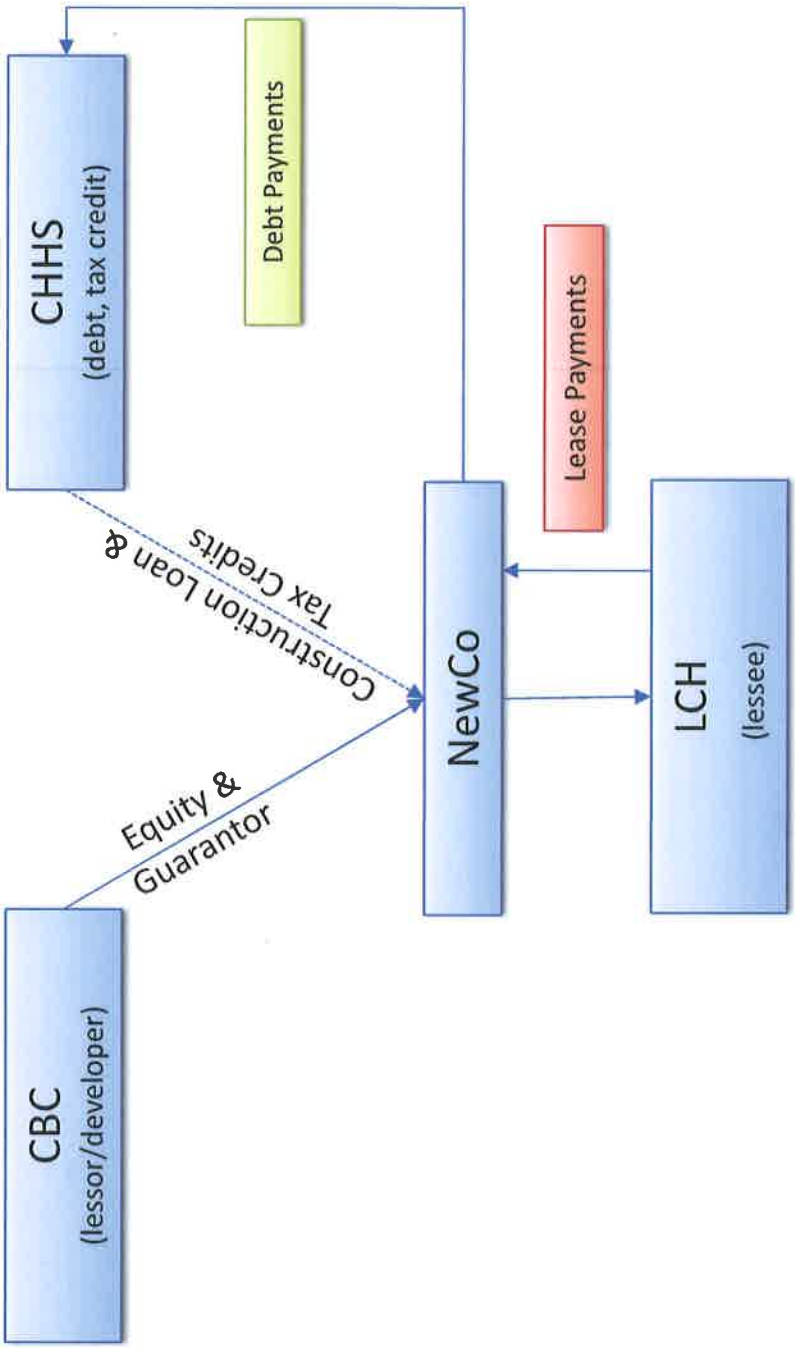
Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 2

Question 3, Section B, Item I

Project Diagram


CHHS
(debt, tax credit)
Debt Payments
Lease Payments
Construction Loan &
Tax Credits
NewCo
LCH
(lessee)
Equity &
Guarantor
CBC
(lessor/developer)

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 3

Question 5- Section C, Economic Feasibility, Item I

Comparison of Fair Market Value to Total Lease Payments

Attachment 3
Comparison of FMV to Total Lease Payments

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

CAH 11 (Lauderdale Community Hospital)
Comparison of Fair Market Value to Total Lease Payments

Fair Market Value		
Land	82,321	82,321
Building		
Construction	14,023,308	
Sitework	1,290,053	
Architectural and Engineering Fees	1,145,147	
Contingency Fund	1,190,952	
CON Fee	44,999	
Reserve for One Yr's Debt Service	2,350,000	20,044,459
Fair Market Value of Land and Building		20,126,780
Lease Payments		
Year #1	2,115,000	
Year #2	2,146,725	
Year #3	2,178,926	
Year #4	2,211,610	
Year #5	2,244,784	
Year #6	2,278,456	
Year #7	2,312,633	
Year #8	2,347,322	
Year #9	2,382,532	20,217,987
Total of All Lease Payments during the Term		20,217,987

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 4

Question 6- Section C, Economic Feasibility, Item II

CHHS Letter of Intent and Overview

Attachment 4
Question 6
CHHS Letter of Intent and Overview

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

CHHS
Community Hospitality Healthcare Services

January 8th, 2016

Jim Shaffer, President
CAH Acquisition Company 11, LLC
d/b/a Lauderdale Community Hospital
1100 Main, Suite 2350
Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,
Community Hospitality Healthcare Services has received an array of information regarding the proposed replacement of the Lauderdale Hospital facility located in Ripley, Tennessee. As a federally certified "Community Development Entity" (CDE) by the CDFI Fund at the US Treasury with a national footprint, we would be interested in providing a sub-allocation of New Markets Tax Credits to the project. With a focus on healthcare infrastructure and job creation in distressed communities, we have funded dozens of projects with similar attributes. The project is located in a highly qualified census tract within a rural community. Based upon the geography and initial estimates of community impacts, including creation of quality jobs and services provided to the community, the project meets our initial thresholds for underwriting. Receipt of final NMTC investment from CHHS is contingent upon:

-Obtaining all necessary entitlements and approvals required by law, including Certificates of Need;
-Securing first-lien debt and additional capital sources required to fully fund the project;
-Collection of additional transaction diligence items;
-Availability of allocation at the time the project is ready to commence closing process; and
-Final underwriting and approval.

We anticipate that the NMTC investment will provide up to 23% of the capital required to complete the project, in the form of a subordinated interest-only note with a term of no less than 7 years at an interest rate in the 2.5-3% range. We look forward to working with you on this highly impactful project.

Sincerely,

Benjamin Cirka
Executive Director
Community Hospitality Healthcare Services

What is the relationship between HMC/CAH Consolidated, Inc. and Community Hospitality Healthcare Services (CHHS).

CHHS is a Community Development Entity which is required when utilizing New Market Tax Credits. Once the facility is built and the NewCo established, CHHS will become part of the NewCo.

Please provide an overview of CHHS.

CHHS is a nationally recognized community development entity specializing in investing in healthcare businesses and healthcare infrastructure in America's most severely distressed communities. CHHS provides catalytic debt and equity investments to high-impact projects in medically underserved low-income communities throughout the U.S. Investments are prioritized based upon their ability to provide healthcare services to low-income individuals and families, and provide entry-level jobs and upward mobility via career ladder resources. These investments have reduced the overall cost burden of care on a national basis while addressing disparities in low-income communities by providing increased access to care and employment opportunities. Project funding provides for expansion of services, construction and improvement of new or existing space, investments in job training, workforce development and career ladder programs as well as computer systems and medical equipment.

CBC Real Estate Group, LLC has a combined experience of over 100 years in commercial real estate development, brokerage, leasing, financing and property management. CBC principals combine to maintain real estate and financial holdings exceeding $400,000,000. During the last 30 years, CBC has been involved in the development and acquisition of more than 5 million square feet of commercial real estate projects throughout the country.

CFG is a leading provider of full-service, comprehensive financing solutions for healthcare facilities across the country.

5. **Section B. I. Project Description**

The applicant notes total project cost for the new facility will be approximately $23 million, of which $3 million (or approximately 23%) will be New Market Tax Credits on pages 6 and 23. However, there appears to be a calculation error in the percentage calculation. Please clarify.

The anticipated percentage is actually 15%. CHHS anticipates that the tax credits could cover as much as 23%, but the applicant used a more conservative 15%.

In addition, the Project Costs Chart totals $20,044,459, not $23,000,000 as reflected in the Project Summary on page 6. Please clarify.

The total project comes out to $23,000,000 because there is $3,000,000 of debt refinancing included in the project. However, because the refinancing is not related in any way to the construction, it was excluded from the "Projects Costs Chart." For purposes of this application the total project cost is $20,126,780.

Please provide an overview of New Market Tax Credits (NMTC) and how it applies to this project.

The New Markets Tax Credit Program (NMTC) was designed by Congress to attract private-sector capital investment into the nation's low-income areas to help stimulate economic growth and create jobs by financing community development projects and business expansion.

This program was established by Congress in December 2000 as a credit against federal income taxes for making qualified equity investments in investment vehicles known as Community Development Entities (CDEs). The credit provided to the investor (either corporate or individual) totals 39 percent of the cost of the investment and is claimed over a seven-year period. The CDE's are charged with making investments into qualified projects or businesses in low-income communities.

The program is overseen by the Community Development Finance Institutions Fund, an arm of the US Treasury Department. It is run on a competitive basis, providing the authority to allocate the resource to projects and businesses to the specialized entities noted above- Community Development Entities. Rules regarding the types of businesses that can be funded and the types of funding that can be provided are extensive and it is a function of the CDE's receiving the allocations to make sure that the projects receiving allocations are compliant with the program. Specific exclusions include land-banking, golf courses, massage parlors and tanning salons as well as farms and liquor stores. The resource is often used to help finance the gap on commercial real estate projects and to fund business expansion. Each CDE that receives an allocation has specific guidelines that it must meet in order to remain in compliance with its agreement to use the resource. It is important to find out from the CDE that you may be working with if your project is eligible for their resources early on.

Many projects blend other sources of subsidy with the New Markets Tax Credit. Historic Credit, both federal and state, Brownfield grants and notes and tax-incremental financing are common additional resources that are used to help make transactions more financially viable. One important thing to remember when you are considering a NMTC subsidized project, however, is that this resource is only able to fill a financial gap; it will not make an infeasible project feasible.

New Markets Tax Credit represents $3,000,000 or 15 % of the funding for this project.

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 5

Question 9- Section C, Orderly Development, Item 7.d

Latest Certificate of Accreditation

DNV·GL

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
188730-2015-AHC-USA-NIAHO	8/1/2015	8/1/2018

This is to certify that:

Lauderdale Community Hospital

326 Asbury Ave, Ripley, TN 38063

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Lack of continual fulfillment of the conditions set out in the Certification/Accreditation Agreement may render this Certificate invalid.

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Replacement Page 3R

Section A

SUPPLEMENTAL #2

February 23`, 2016

9:32 am

5. ***Name of Management/Operating Entity (If Applicable)***

Rural Community Hospitals of America, LLC
Name

1100 Main Street, Suite 2350
Street or Route

Jackson
County

Kansas City
City

MO
State

64105
Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership		D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify)	
C.	Lease of 9 Years	✓			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) CAH	✓	I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		K.	Recuperation Center	
D.	Home Health Agency		L.	Rehabilitation Facility	
E.	Hospice		M.	Residential Hospice	
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility	
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify)	
			Q.	Other (Specify)	

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A.	New Institution		G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B.	Replacement/Existing Facility	✓			
C.	Modification/Existing Facility				
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)		H.	Change of Location	
			I.	Other (Specify)	
E.	Discontinuance of OB Services				
F.	Acquisition of Equipment				

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Replacement Page

Section B

Project Costs Chart

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	0
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	0
3.	Acquisition of Site	0
4.	Preparation of Site	0
5.	Construction Costs	0
6.	Contingency Fund	0
7.	Fixed Equipment (Not included in Construction Contract)	0
8.	Moveable Equipment (List all equipment over $50,000)	0
9.	Other (Specify)	0
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	20,217,987
2.	Building only	0
3.	Land only	0
4.	Equipment (Specify)	0
5.	Other (Specify)	0
C.	Financing Costs and Fees:	
1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve for One Year's Debt Service	0
4.	Other (Specify)	0
D.	Estimated Project Cost (A+B+C)	20,217,987
E.	CON Filing Fee	45,000
F.	Total Estimated Project Cost (D+E)	20,262,987
	TOTAL	20,262,987

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

Lauderdale Community Hospital

Tennessee Certificate of Need

Replacement Page

Section C

Historical and Projected Data Charts

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in OCTOBER (Month).

		Year 2013	Year 2014	*Year 2015*
A.	Utilization Data (Patient Days)	2,398	2,164	*2,189*
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 6,862,824	$ 5,450,236	*$ 5,789,102*
2.	Outpatient Services	24,086,893	27,208,705	*27,848,838*
3.	Emergency Services	7,724,520	6,696,963	*7,834,002*
4.	Other Operating Revenue (Specify) Cafeteria, Med Records, MCR HER, Grant Income	$ 522.385	$ 615,350	*$ 500,784*
	Gross Operating Revenue	**$ 39,196,622**	**$ 39,971,254**	**$ 41,972,726**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$ 19,817,700	$ 20,231,496	*$ 23,976,735*
2.	Provision for Charity Care	837,130	176,674	*274,237*
3.	Provisions for Bad Debt	3,415,875	3,835,255	*2,843,619*
	Total Deductions	**$ 24,070,705**	**$ 24,243,426**	**$ 27,094,591**
NET OPERATING REVENUE		**$ 15,125,917**	**$ 15,727,828**	**$ 14,878,135**
D.	Operating Expenses			
1.	Salaries and Wages	$ 5,884,252	$ 6,141,906	*$ 6,244,450*
2.	Physician's Salaries and Wages	150,611	150,412	*43,187*
3.	Supplies	1,250,825	1,301,259	*1,279,405*
4.	Taxes	152,790	613,239	*270,108*
5.	Depreciation	915,401	989,069	*849,949*
6.	Rent	0	0	*0*
7.	Interest, other than Capital	80,431	69,960	*103,759*
8.	Management Fees:			
	a. Fees to Affiliates	_____	_____	_____
	b. Fees to Non-Affiliates	1,413,991	1,419,996	1,618,373
9.	Other Expenses – Benefits, Med Specialist Fees, Purchased Services, Leases, Licenses, Utilities, Property Tax	4,956,309	4,019,391	*4,167,110*
	Total Operating Expenses	**$ 14,804,610**	**$ 14,705,232**	**$ 14,576,341**
E.	Other Revenue (Expenses) – Offset to Income Taxes_____	$ 0	$ 479,059	*$ 150,053*
NET OPERATING INCOME (LOSS)		**$ 321,307**	**$ 1,501,655**	*$* **451,847**
F.	Capital Expenditures			
1.	Retirement of Principal	$ 435,016	$ 605,887	*$ 1,002,827*
2.	Interest	322,017	318,794	*122,062*
	Total Capital Expenditures	**$ 757,033**	**$ 924,681**	*$* **1,124,890**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ (435,726)**	**$ 576,974**	**$(673,043)**

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in October (Month).

		Year_2018_	Year_2019_
A.	Utilization Data (Patient Days)	2,427	2,524
B.	Revenue from Services to Patients		
1.	Inpatient Services	6,940,971	7,435,168
2.	Outpatient Services	34,395,985	36,642,245
3.	Emergency Services	8,572,030	9,005,774
4.	Other Operating Revenue (Cafeteria, Med Records, HER, MCR, Grant Income)_	448,828	448,828
	Gross Operating Revenue	**50,357,814**	**53,532,015**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	27,499,852	29,355,003
2.	Provision for Charity Care	330,028	351,017
3.	Provisions for Bad Debt	4,940,990	5,255,236
	Total Deductions	**32,770,870**	**34,961,256**
NET OPERATING REVENUE		**17,586,944**	**18,570,759**
D.	Operating Expenses		
1.	Salaries and Wages	5,530,704	5,710,700
2.	Physician's Salaries and Wages	0	0
3.	Supplies	1,758,823	1,857,205
4.	Taxes	482,600	642,454
5.	Depreciation	1,277,778	1,277,778
6.	Rent	0	0
7.	Interest, other than Capital	42,674	42,674
8.	Management Fees:		
	a. Fees to Affiliates	0	0
	b. Fees to Non-Affiliates	1,934,706	2,042,925
9.	Other Expenses – Benefits, Purch Svcs, Benefits, Other Op	4,129,427	4,362,648
	Total Operating Expenses	**15,156,712**	**15,936,384**
E.	Other Revenue (Expenses) – Offset Income Taxes_____	261,990	438,012
NET OPERATING INCOME (LOSS)		**2,692,222**	**3,072,388**
F.	Capital Expenditures		
1.	Retirement of Principal	638,677	636,573
2.	Interest	2,045,333	1,990,877
	Total Capital Expenditures	**2,684,010**	**2,627,450**
NET OPERATING INCOME (LOSS)			

LESS CAPITAL EXPENDITURES	8,212	444,938

SUPPLEMENTAL #2
February 23`, 2016
9:32 am

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	*Year 2015*
1. BENEFITS	$ 1,338,183	$ 1,424,873	*$ 1,367,552*
2. MEDICAL SPECIALIST FEES	656,572	655,464	*687,866*
3. PURCHASED SERVICES	878,541	871,526	*695,203*
4. Utilities	491,886	465,095	*432,071*
5. Leases	73,345	54,651	*329,112*
6. Insurance Expense	371,371	425,422	*455,184*
7. Licenses, Repairs & Maint, Dues, Chapter 11, et al	1,299,201	385,353	*200,122*
Total Other Expenses	**$ 5,109,099**	**$ 4,282,384**	***$ 4,167,110***

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Benefits	1,372,160	1,471,506
2. Medical Specialist Fees	730,497	745,107
3. Purchased Services	629,263	641,848
4. Utilities	258,395	266,147
5. Leases	396,066	421,256
6. Insurance Expense	547,786	582,625
7. Licenses, Repairs and Maint, Dues, et al	195,260	234,159
Total Other Expenses	**4,129,427**	**4,362,648**

ADDITIONAL INFORMATION

CAH Acquisition 11 d/b/a Lauderdale Community Hospital

CN1601-004

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in OCTOBER (Month).

		Year 2013	Year 2014	*Year 2015*
A.	Utilization Data (Patient Days)	2,398	2,164	*2,189*
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 6,862,824	$ 5,450,236	*$ 5,789,102*
2.	Outpatient Services	24,086,893	27,208,705	*27,848,838*
3.	Emergency Services	7,724,520	6,696,963	*7,834,002*
4.	Other Operating Revenue (Specify) Cafeteria, Med Records, MCR HER, Grant Income	$ 522.385	$ 615,350	*$ 500,784*
	Gross Operating Revenue	**$ 39,196,622**	**$ 39,971,254**	**$ 41,972,726**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$ 19,817,700	$ 20,231,496	*$ 23,976,735*
2.	Provision for Charity Care	837,130	176,674	*274,237*
3.	Provisions for Bad Debt	3,415,875	3,835,255	*2,843,619*
	Total Deductions	**$ 24,070,705**	**$ 24,243,426**	**$ 27,094,591**
NET OPERATING REVENUE		**$ 15,125,917**	**$ 15,727,828**	**$ 14,878,135**
D.	Operating Expenses			
1.	Salaries and Wages	$ 5,884,252	$ 6,141,906	*$ 6,244,450*
2.	Physician's Salaries and Wages	150,611	150,412	*43,187*
3.	Supplies	1,250,825	1,301,259	*1,279,405*
4.	Taxes	152,790	613,239	*270,108*
5.	Depreciation	915,401	989,069	*849,949*
6.	Rent	0	0	*0*
7.	Interest, other than Capital	80,431	69,960	*103,759*
8.	Management Fees:			
a.	Fees to Affiliates	_____	_____	_____
b.	Fees to Non-Affiliates	1,413,991	1,419,996	1,618,373
9.	Other Expenses – Benefits, Med Specialist Fees, Purchased Services, Leases, Licenses, Utilities, Property Tax	4,956,309	4,019,391	*4,167,110*
	Total Operating Expenses	**$ 14,804,610**	**$ 14,705,232**	**$ 14,576,341**
E.	Other Revenue (Expenses) – Offset to Income Taxes_____	$ 0	$ 479,059	*$ 150,053*
NET OPERATING INCOME (LOSS)		**$ 321,307**	**$ 1,501,655**	**$ 451,847**
F.	Capital Expenditures			
1.	Retirement of Principal	$ 435,016	$ 605,887	*$ 1,002,827*
2.	Interest	322,017	318,794	*122,062*
	Total Capital Expenditures	**$ 757,033**	**$ 924,681**	**$ 1,124,890**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ (435,726)**	**$ 576,974**	**$(673,043)**

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in October (Month).

		Year_2018_	Year_2019_
A.	Utilization Data (Patient Days)	2,427	2,524
B.	Revenue from Services to Patients		
1.	Inpatient Services	6,940,971	7,435,168
2.	Outpatient Services	34,395,985	36,642,245
3.	Emergency Services	8,572,030	9,005,774
4.	Other Operating Revenue (Cafeteria, Med Records, HER, MCR, Grant Income)_	448,828	448,828
	Gross Operating Revenue	**50,357,814**	**53,532,015**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	27,499,852	29,355,003
2.	Provision for Charity Care	330,028	351,017
3.	Provisions for Bad Debt	4,940,990	5,255,236
	Total Deductions	**32,770,870**	**34,961,256**
NET OPERATING REVENUE		**17,586,944**	**18,570,759**
D.	Operating Expenses		
1.	Salaries and Wages	5,530,704	5,710,700
2.	Physician's Salaries and Wages	0	0
3.	Supplies	1,758,823	1,857,205
4.	Taxes	482,600	642,454
5.	Depreciation	1,277,778	1,277,778
6.	Rent	0	0
7.	Interest, other than Capital	42,674	42,674
8.	Management Fees:		
	a. Fees to Affiliates	0	0
	b. Fees to Non-Affiliates	1,934,706	2,042,925
9.	Other Expenses – Benefits, Purch Svcs, Benefits, Other Op	4,129,427	4,362,648
	Total Operating Expenses	**15,156,712**	**15,936,384**
E.	Other Revenue (Expenses) – Offset Income Taxes_____	261,990	438,012
NET OPERATING INCOME (LOSS)		**2,692,222**	**3,072,388**
F.	Capital Expenditures		
1.	Retirement of Principal	638,677	636,573
2.	Interest	2,045,333	1,990,877
	Total Capital Expenditures	**2,684,010**	**2,627,450**
NET OPERATING INCOME (LOSS)			

LESS CAPITAL EXPENDITURES	**8,212**	**444,938**

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	*Year 2015*
1. BENEFITS	$ 1,338,183	$ 1,424,873	*$ 1,367,552*
2. MEDICAL SPECIALIST FEES	656,572	655,464	*687,866*
3. PURCHASED SERVICES	878,541	871,526	*695,203*
4. Utilities	491,886	465,095	*432,071*
5. Leases	73,345	54,651	*329,112*
6. Insurance Expense	371,371	425,422	*455,184*
7. Licenses, Repairs & Maint, Dues, Chapter 11, et al	1,146,411	122,360	*200,122*
Total Other Expenses	**$ 4,956,309**	**$ 4,019,391**	***$ 4,167,110***

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Benefits	1,372,160	1,471,506
2. Medical Specialist Fees	730,497	745,107
3. Purchased Services	629,263	641,848
4. Utilities	258,395	266,147
5. Leases	396,066	421,256
6. Insurance Expense	547,786	582,625
7. Licenses, Repairs and Maint, Dues, et al	195,260	234,159
Total Other Expenses	**4,129,427**	**4,362,648**

AFFIDAVIT

STATE OF Missouri

COUNTY OF Jackson

Trent Skaggs, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Trent Skaggs
SIGNATURE/TITLE

Sworn to and subscribed before me this 25th day of February (Month), 2016 (Year) a Notary Public in and for the County/State of Jackson / Missouri.

Therese M. Riley
NOTARY PUBLIC

My commission expires 10-9 (Month/Day), 2016 (Year).

THERESE M. RILEY
Notary Public - Notary Seal
STATE OF MISSOURI
Jackson County
My Commission Expires: Oct. 9, 2016
Commission # 12802976